MEDICARE+CHOICE: AN EVALUATION OF THE PROGRAM

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MEDICARE+CHOICE: AN EVALUATION OF THE PROGRAM

WEDNESDAY, AUGUST 4, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m. in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Stearns, Greenwood, Burr, Ganske, Bryant, Brown, Pallone, Deutsch, Green, Barrett, Capps, Hall, and Eshoo.

Staff present: Tom Giles, majority counsel; Jason Lee, majority counsel; Bridgett Taylor, professional staff; Amy Droskoski, professional staff; and Robert Simison, legislative clerk.

Mr. BILIRAKIS. The hearing will come to order.

In February, this subcommittee focused on efforts by the Health Care Financing Administration to implement a risk adjustment model for the Medicare+Choice program. Today we will reexamine the impact of HCFA's planned risk adjustor and its effect on the continued viability of this important program.

Two years ago Congress established the Medicare+Choice program as part of the 1997 Balanced Budget Act. The legislation was enacted with strong bipartisan support to increase the health care options available to America's senior citizens.

Today, about 17 percent of Medicare beneficiaries participate in a Medicare+Choice plan. Many of these plans provide benefits such as prescription drug coverage, which are not available through traditional fee-for-service Medicare.

Since our last hearing, the July 1st deadline has passed for plans to inform HCFA of their intent to alter or terminate their contracts. Nearly 100 plans have decided to withdraw from the Medicare+Choice program, reduce those service areas, or scale back their benefit packages. Many of these plans cited cuts in funding proposed by HCFA as a major factor in their decisions.

As a result, 327,000 beneficiaries will lose their current health coverage next year. For 79,000 of these beneficiaries, no other Medicare managed care plan will be available in their area. In Florida, alone, 29,000 beneficiaries will be affected by plan withdrawals, and 10,000 will have no alternative but to return to fee-for-service Medicare.

The 1997 Balanced Budget Act required HCFA to establish a process for adjusting Medicare+Choice payments based on the like-

lihood or risk that enrollees will use health care services. The risk adjustment process was intended to distribute funds based on the health status of Medicare+Choice enrollees. Neither Congress nor the Congressional Budget Office assumed that implementation of the risk adjustor would result in funding cuts. It was intended to redistribute moneys based on the health status of beneficiaries, without reducing overall funding for the program.

Unfortunately, HCFA has proposed a risk adjustment model that would impose deep spending cuts in the Medicare+Choice program. Estimates indicate over $11 billion may be drained from the program under HCFA's proposed risk adjustor, and I believe that estimate came from HCFA. We'll get into that.

In response, my colleague, Peter Deutsch of Florida, joined me in introducing H.R. 2419, the Medicare+Choice Risk Adjustment Amendments of 1999. Our bill will ensure that the risk adjustor is implemented on a budget-neutral basis, consistent with Congressional intent.

I am deeply concerned about the impact of any instability in the Medicare+Choice program and our most vulnerable seniors. Choosing a health care plan can be a difficult task for all of us, and it is particularly hard for the frail elderly. They deserve the health care options we promised them when we created the Medicare+Choice program.

If HCFA is allowed to go forward with its ill-advised proposal, Medicare beneficiaries will face devastating consequences, particularly low-income seniors.

In addition to increased costs and reductions in benefits, many beneficiaries will lose the option of participating in a Medicare managed care plan altogether.

For many seniors, Medicare+Choice is an important source of prescription drug coverage. Clearly, we must preserve this option for beneficiaries who choose to participate in a Medicare managed care plan. However, we must do more to increase access to prescription drugs for seniors who need them.

No senior should be forced to choose between buying groceries and filling a prescription. A nation is judged by how it treats its most vulnerable citizens, and we must help our neediest seniors obtain prescription drugs.

Over the past several months, I have been working to develop a plan that meets this objective, and specifically this proposal would assist States in establishing and expanding programs to help low-income beneficiaries obtain prescription drugs, preserve seniors' health options, including prescription drug coverage available through the Medicare+Choice program, and create incentives for plans to expand prescription drug coverage at no additional premium for seniors, and establish a Federal stop loss program to protect beneficiaries who have high annual prescription drug costs.

By contrast, the President's plan is overly broad and spreads resources too thin. As a result, it provides only a limited benefit to individuals. By targeting assistance to beneficiaries who are low income or have high drug costs, we can more effectively, I think, help seniors in need.

Furthermore, the President's plan would not even take effect until 2002 and it would not be fully implemented until 2008 be-

cause of the time needed to create the new bureaucracy of a Medicare Part B. It would do nothing for the poorest and sickest seniors who need help right now. And even after it is fully implemented in 2008, the plan will force seniors who have high annual drug costs to fend for themselves.

I was proud to serve with the National Bipartisan Medicare Commission, and I remain committed to enacting comprehensive reforms to protect the program for the future. I believe we can help the neediest seniors while preserving and strengthening Medicare for current beneficiaries and future generations. We can accomplish both goals without increasing—and I emphasize without increasing—beneficiaries' premiums or jeopardizing the fiscal stability of Medicare.

I look forward to working with my colleagues on both sides of the aisle to further refine this plan. I hope it can serve as a vehicle for a bipartisan effort to help seniors obtain the prescription drugs they need.

I want to thank all of our witnesses, certainly particularly Dr. Berenson and all of the others for joining us today to discuss the important role of Medicare+Choice program in providing health care options for seniors.

I now yield to the ranking member from Ohio, Mr. Brown.

Mr. BROWN. I thank you, Mr. Chairman.

I'd especially like to thank Dr. Berenson and Marilyn Moon and Karen Ignagni and other distinguished witnesses for joining us.

As many of you know, I am not a strong proponent of the plus-Choice program. I think, in fact, we made a mistake when we passed the program as part of the Balanced Budget Act. The plus-Choice program segments the Medicare risk pool.

Traditional Medicare program provides equal access to benefits for every senior. Plus-Choice introduces different levels of benefits into the program—benefits such as prescription drug coverage that all seniors need but only some seniors get.

The plus-Choice program diverts money toward profits that otherwise could be invested in improved benefits for every senior, and it generates a huge amount of uncertainty for seniors.

Can they depend on their health plan to stick with them? No. Can they depend on promised benefits? No. Can they depend on consistent coverage decisions? No.

That volatility is why we are here today. There are 13,031 seniors in Ohio, alone, in my State, that will be dropped by their health plans effective January 1, 2000. I've heard from several seniors who are going through this for the second time.

When traditional Medicare is being demonized because it costs a lot to provide health care coverage, it doesn't have the luxury of blaming it on big government. It can't reduce cost. It can't make a statement by dropping Medicare beneficiaries or wiping out promised benefits.

It would be easier and cheaper if the Medicare program could take those steps, but it wouldn't be the right thing to do. The public wouldn't stand for it, nor should they. That's the nature of a public program.

But being locked into less-profitable markets is anathema to the private market. The success of plus-Choice relies on the faulty

premise that private sector incentives will produce the right amount of the right health care delivered in a reliable way.

Realistically, what private sector incentives may produce is cheaper health care. Unfortunately, cheap is not a proxy for right or reliable, nor does cheap care necessarily lead to lower Federal cost.

We're losing money in managed care today, and with a lobby as strong as the insurance industry, payment rates won't go anywhere but up. It is unrealistic to expect private health plans to ignore profitability, when profitability is being pitted against individual well-being or the public good. Health plans will try to squeeze as much money from the Federal Government as they can. That doesn't make them evil. It makes them good businessmen and good businesswomen.

Consistent with profit motives that are not, in themselves, bad or good—they are inherent in the market—health plans enroll seniors 1 year, promising them all kinds of benefits, and desert them the next year. They attract seniors by offering supplemental benefits, but when costs exceed projections, benefits are taken away.

Where does that leave the Federal Government? Between a rock and a hard place. If we don't pay health plans more, additional seniors will lose prescription drug and other supplemental benefits. But when a senior joins a health plan based on the premise of supplemental benefits, the term "supplemental" no longer really fits. Seniors come to depend on these benefits, and it is a true loss when health plans drop them.

If we do pay health plans more, the money has to come from somewhere. Dollars that could be devoted to providing prescription drug coverage for all Medicare beneficiaries would, instead, be channeled into prescription drug coverage for some Medicare beneficiaries. It is a catch 22, pure and simple.

Finally, giving over Medicare to the insurance industry allows the Federal Government to pass the buck on the hard health care decisions. It takes the pressure off us when the pressure should be on us. Health care costs are increasing, the elderly population is increasing. We need to acknowledge the implications and figure out what to do next.

There is one potential advantage to promoting private managed care plans—shifting seniors' health care coverage to the private market would stifle the power of multiple special interest groups to play havoc on Federal Medicare legislation. Unfortunately, all we would be doing, though, is trading multiple special interest groups for one big one, the insurance industry.

But, regardless of the broader issues around plus-Choice, the reality is that 6.2 million seniors are enrolled in plus-Choice and we have to deal with the situation at hand. Congress has a responsibility to pay plus-Choice plans adequately. Plus-Choice plans have a responsibility to prove that current rates are inadequate.

The American Association of Health Plans says there is a fairness gap between managed care and fee-for-service payments, but, as far as I know, they have not shared supporting data or the methodology they used to reach this conclusion.

AAHP is concerned about a fairness gap. I'm concerned about a data gap. Some health plans are clearly losing money in some

counties, but what does this mean? Does it mean that large health plans like Aetna and Cigna cannot cross-subsidize from more-profitable to less-profitable counties? Show us the cost data. Are plans being under-paid in every county? Show us the cost data. Do some health plans underestimate the cost of supplemental benefits? Show us the cost data. Did Congress underestimate how much it would cost health plans to cover basic benefits, or did health plans over-estimate their ability to cut cost? Can we see how they spend the money that we pay them? Is the problem that we removed GME funding from managed care rates? Ostensibly, that reduction would have an impact only in GME spending. It should be a wash.

I don't think managed care plans are sinister and I do think that, along with the Medicare program, they've led the way in eliminating unnecessary costs from the practice of medicine, but I do not think that Congress or taxpayers we represent should be asked to pay managed care plans more until they provide the answers and the data we need to pay them correctly.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentlemen.

Dr. Ganske, for an opening statement.

Mr. GANSKE. Thank you, Mr. Chairman. I'll be brief.

I need to tell you, Mr. Chairman, that I won't be able to stay for the whole hearing because I have work to do on managed care reform.

Mr. Chairman, I don't consider HCFA's risk adjustor to be ill-considered. With all due respect, senior citizens in Florida already have a richer HMO benefit package than anything we will ever see in Iowa.

Some people talk about a fairness gap. Well, Mr. Chairman, I don't think it is fair that seniors in Florida get prescription drugs and those in Iowa never will.

We do need risk adjustment.

Let me tell you about a T-shirt that I received about 2 years ago. It was from a Medicare HMO in one of the southern States, southwest States. It was an inducement for seniors to join a Medicare HMO and join the Silver Sneaker Club.

The benefit touted was a health fitness club. On the surface, that may seem like, gee, that's a neat thing. That would help keep people healthy, right? It also serves as a risk selector, because which Medicare recipient is going to be interested in joining a health fitness club except somebody who is healthy? So you've got a very subtle inducement there to select out the healthier patient.

We've had GAO reports, one after another, pointing out how HMO Medicare beneficiaries, on the average, cost something like $0.65, compared to $1 for fee-for-service, until they disenroll, and at that time they end up costing Medicare fee-for-service $1.65. I mean, there clearly is a need for risk adjustment, and I applaud HCFA's attempts to do this. It's not easy.

Now, do we need more money? Do we need to do some adjustment for Medicare for the 1997 Balanced Budget Act? You bet we do. I've got rural hospitals that are on the cusp. We've got teaching hospitals around the country that need an adjustment.

And part of my frustration with this entire budgetary process and the tax cut process has been that, instead of handling these

needed expenditures first and then figuring out what you're going to have left for a tax cut, we've got the cart before the horse. It is that simple.

Well, Mr. Chairman, if it is going to come down to passing a large tax cut and then also passing emergency spending for such emergencies as the census, and then also doing emergency funding for true emergencies, like the farm crisis that we have, there isn't going to be much left over. So maybe, Mr. Chairman, I should make a suggestion. If we are going to have to go back into the 1997 BBA and do an adjustment for Medicare, maybe we ought to go back and start looking at some revenues from tobacco. Maybe we ought to go back and look at the Federal Government recovering some of the moneys that the tobacco companies have given to the States and utilize that for Medicare.

Mr. Chairman, this is the Health and Environment Subcommittee. We have jurisdiction over this. Maybe we ought to start looking at a tobacco tax bill, or maybe we ought to start looking at recovering some of those tobacco moneys so that we can utilize them in health care. We have reports from around the country right now, Mr. Chairman, where those tobacco moneys are being used by States for non-health-care items. I don't think that's right. I suspect most of the people on this subcommittee would feel the same way.

But we have a lot to talk about, Mr. Chairman, and I'm glad you are holding this hearing. I'll be very interested in the testimony that we are about to receive.

Thank you.

Mr. BILIRAKIS. I thank the gentleman.

The gentlewoman from California, Ms. Eshoo.

Ms. ESHOO. First, Mr. Chairman, thanks to you for your leadership in holding this hearing today. It is the second this year to monitor the progress of Medicare+Choice, the program Medicare+Choice.

I'd like to ask for unanimous consent to submit my formal statement into the record.

Mr. BILIRAKIS. Without objection, the written statement of all members of the subcommittee will be made a part of the record.

Ms. ESHOO. Thank you.

I look forward to hearing the testimony of those that are here today to give it. Obviously, there will be conflicting testimony. From the industry, itself, I suspect they will be saying that there's not enough in the program, that the reimbursements are not fair enough, they're not high enough, and that's why they are withdrawing from so many markets, including some parts of my Congressional District, where seniors are absolutely outraged. And we are going to hear something else from HCFA.

So I'm going to withhold at least some of my judgment until I hear from them, and thank you again for holding the hearing. It is an important one.

What I might add is that my colleague, Dr. Ganske, I think really characterized the very large picture in terms of what the Congress is taking on right now, and that is our overall budget and the tax cuts. I think the cart is really coming before the horse, because we don't see, at least in one of the major plans, anything that will

address the shortcomings of Medicare, and here we are having probably one of the most important hearings on the entire Hill, with discrepancies between what HCFA views and what the private sector views this issue, and yet, in the major republican plan, there's not a dime—not a dime. You can reform Medicare as much as you want, but there isn't anything that shows that if you don't add some more resources that it really is going to work.

So today should be interesting. Thank you, Mr. Chairman, for holding the hearing again.

[The prepared statement of Hon. Anna G. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you, Mr. Chairman. I'm very happy that we are having this hearing today, the second this year to monitor the progress of the Medicare+Choice program.

There are few programs that are as critical to our Nation's senior citizens as Medicare.

As the primary health care provider for the over-65 population, Medicare is ultimately responsible for the well-being of our parents, our grandparents, and ultimately ourselves.

That is why it is so critical that we, in Congress, do everything in our power to ensure its long-term solvency.

I am an avid supporter of the President's plan to dedicate 15% of the budget surplus to Medicare, ensuring its solvency until the year 2020.

When we passed the Balanced Budget Act in 1997, we recognized that the way we reimburse health plans for Medicare is inefficient and results in a glut of overpayment.

According to GAO, Medicare overpaid health plans $1.3 billion in 1998 alone.

Implementation of the new payment methodology will save the federal government billions of dollars in overpayments by providing us with the necessary information to ensure that reimbursements reflect costs.

More importantly, the new methodology will remove the present incentive on the part of some plans to focus on enrolling healthier seniors and avoid the sicker, most needy ones.

While this new system promises to cut the fat out of Medicare, there are some who say it has gone too far.

Last year, nearly 100 managed care companies pulled out of the Medicare program, or significantly scaled back their services. And they say it is because the reimbursement rates are too low to make a profit.

I question the validity of this argument but, nonetheless, I am concerned that something needs to be done to prevent further pullouts.

Seniors need quality, reliable health care. They should not be forced to pay for health insurance today that may not be there for them tomorrow.

So, thank you Mr. Chairman for providing us with this opportunity to take another look at this important program. I look forward to hearing from the witnesses.

Mr. BILIRAKIS. I thank the gentlelady.

Mr. Bryant, an opening statement?

Mr. BRYANT. Thank you, Mr. Chairman.

Today, nearly 40 million Americans rely on Medicare for their health care, and approximately 6.2 million beneficiaries are enrolled in the Medicare+Choice program. Congress created this new program with the BBA in 1997 to offer Medicare beneficiaries new private health plan options—in other words, to give seniors a choice among plans. Most of these private plans offer the beneficiaries a more generous benefit package with fewer out-of-pocket expenses.

I am concerned, however, that last year 99 private health plan Medicare contracts were either terminated or reduced their service areas. This year, the same number of contracts will either not be

renewed or will serve a smaller geographic area. It would appear that the choices Congress intended to provide are now eroding.

We will hear a statistic today that 95 percent of the current enrollees in Medicare+Choice program will be able to continue with their current plan in the year 2000. While that statistic may sound acceptable, I doubt it will give much comfort to the nearly 700 beneficiaries affected by plan withdrawals in my home State of Tennessee. The majority of these seniors will have no other Medicare+Choice plan to turn to.

I was contacted recently—my office in Memphis was—by a woman from that city. She said that she had been very pleased with her Medicare HMO, which, in her case, happens to be United Health Care of Tennessee. She said—and I quote—"I have never felt more secure about my health insurance."

She goes on to say that she used to have traditional fee-for-service, Medicare with supplemental insurance with that, but the cost of this supplemental insurance got so high that she could no longer afford it.

The Medicare+Choice plan provided her with a choice, and it was a very attractive choice. However, her plan is terminating its contract this year and there will be zero remaining Medicare+Choice options for her in Shelby County.

Now, we were contacted by United Health Care, and they gave us an explanation as to why they were, in effect, pulling out of these plans, and I'll read just a part of this letter from United Health Care dated July of this year.

It says, "This difficult decision was made following a thorough analysis of our health plans. Changes brought to health plan reimbursement under the 1997 Balanced Budget Act continue to create operational challenges. Payments to plans are being held to minimum increases, while medical cost trends are increasing at a much higher rate. The untested risk adjustor creates uncertainty regarding future payment adequacy.

"Additionally, there is an increasing inequity between payments to Medicare health plans and the traditional Medicare program, which makes it difficult to offer benefits over and above Medicare's basic benefit package in a number of markets.

"These program changes also hinder our ability to maintain competitive reimbursement contracts with physicians, hospitals, and other providers."

As has been said earlier this morning, there are those in Congress who really aren't for this plan, the ability to offer health care options, and I sometimes wonder if this is not one way that we can squeeze that out of the market and simply go back to the full fee-for-service arrangement with Medicare. I hope that's not the case, because I hope we continue to have choices available for our senior citizens.

For that reason, I think it is important that we on this panel examine the reasons behind all these withdrawals, and I think we ought to do that today if we can do that. I think it is necessary for us to consider payment rates, the risk adjustor administrative and regulatory burdens on the plans, and other possible disincentives for public health or for private health plans to contract with Medicare and to remain in the program.

I also think we should look at how many plans that did not renew their contracts had to increase premiums or reduce their benefits. We also need to remember that these decisions affect Medicare beneficiaries enrolled in the Medicare+Choice program.

To conclude, I look forward to examining these issues this morning and to hearing from our distinguished panel of witnesses. I want to welcome you all and thank you for taking time to be with us today.

Mr. Chairman, I thank you and yield back just on time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Deutsch for an opening statement?

Mr. DEUTSCH. Thank you, Mr. Chairman. Thank you for this hearing. I think it is very important for our constituents, and really for the whole country.

Before I begin with a statement, I just want to respond a little bit to what Congressman Ganske said in his opening statement, because I think it is important to dialog a little, just so that we at least hear how different people, you know, have really 180-degree different perspectives on a lot of things to do with Medicare-plus.

I happened to have visited Iowa, and I happen to like Iowa. My roommate from law school was from Colfax, Iowa. But Iowa is not south Florida, and, for that matter, not Florida, and I think it is totally missing the whole point of how the system is set up to honestly think that the reimbursement level in Colfax, Iowa, should be the same as Miami, Florida. It doesn't deal with reality and cost, and cost of living and cost of everything—cost of rent, cost of insurance, cost of literally every factor that was built in.

So I think that premise which drives some of this issue is a bad premise and a false premise, for that matter, and I think the other—and, going back to where we are, I think it is really important for us, as we are having this debate, to sort of focus in a little bit historically of where we were, where we are, and where we are going to be going if we continue in the direction that we are without changing.

Where we were were some pretty bad old days under Medicare before this option existed. I mean, I think universally we view our job as trying to make America and the world a better place, and universally I think all of us care about our constituents. And if we look at what Medicare beneficiaries had as benefits prior to this option, it wasn't as good. I mean, people were suffering in so many ways in terms of out-of-pocket costs, and Congressman Bryant's letter from a constituent is multiplied by millions in terms of real people and the benefits that they've seen.

Congress ought to be patting ourselves on the back in terms of what we did in terms of cost savings and adjusting it. Nothing we do is perfect. It's a dynamic process. But I guess sort of where we are going—you know, one of the other premises of my colleagues which I really think needs to focus on is many of the HMOs—not all, but majority—are for-profit institutions, which, by definition, is not a bad thing. I think as a society, as a Congress, we understand that.

But to say that they are dropping 327,000 people for manipulative reasons or for other reasons, you know, again, I just think to-

tally defies logic. If they could make it work, they wouldn't be dropping people.

That's the number of people that have been dropped. We also have 70,000 people who had that option who literally do not have that option today.

I think tied into that is—really talking to some of the frustration—and I actually, in terms of my District, have, I guess, the luxury or the—just in my District I both have an urban area, a suburban area in terms of Broward and Dade Counties, but Monroe County is technically a rural health system. If you think about it, it is 120 miles long. In terms of hospitals, where are the hospitals? So technically it is a rural health system. In terms of HMO access, it's not much different than rural farm areas in Iowa—much warmer, much more pleasant, much more colorful.

But I will tell you that, you know, one of the things we ought to be doing and talking about is really how to get service into those areas. I mean, you know, when my colleagues from rural areas talk—I have a statement that I'd be happy to submit for the record.

Mr. GANSKE. Mr. Chairman, I'd ask unanimous consent for 1 additional minute.

Mr. BILIRAKIS. Does the gentleman want an additional minute?

Mr DEUTSCH. I'd be happy to an additional minute and yield to my colleague from the great State of Iowa.

Mr. BILIRAKIS. Well, all right. Let's not overdo this.

Mr. GANSKE. Iowa is 24th in the country in terms of average overhead for providing medical services. It is 48th in the country in terms of reimbursement. And if you look at the average HMO reimbursement per county in my District and compare it to yours, you are receiving more than twice the AAPCC than what my constituents are, and because of that your constituents are able to get a package of benefits that are simply not and never will be available to those in large parts of the country.

And so when we look at how do we fund Medicare HMOs, I think we need to address that issue and come to at least a closer national average than a double difference, and we do need to look at the evidence that we've seen before this committee on why we need a risk adjustor.

Mr. DEUTSCH. Just reclaiming my time very quickly——

Mr. BILIRAKIS. Very quickly, if you could.

Mr. DEUTSCH. And I think the chairman and I and other people from both urban and rural areas have been supportive of trying to make the system more equitable, but, you know, that's where we can get into details. And I think Congress is particularly ill-equipped in some ways to get at that micro-management level of HCFA. We can get policy bases in terms of working with them, and working with them both substantively and administratively to try to correct some of those changes, as we have—as both you and I have in terms of our work on this subcommittee and on the committee.

Mr. BILIRAKIS. The gentleman's time has expired. Of course, I think we should remind the gentleman from Iowa that he played a very large part in these exact discussions regarding the adjusting of the AAPCC and, consequently, there were adjustments made

which are very favorable to the rural areas, and much of that was a result of his efforts.

Ms. Capps for an opening statement?

Ms. CAPPS. Thank you, Mr. Chairman, for holding this hearing.

Medicare is a critically important program for seniors. It has resulted in a measure of security for retirees and the disabled that was unthinkable in the years before it was enacted.

I am so appreciative that we are having this hearing today to look at how the latest major change to Medicare, the Medicare+Choice program, has been working.

For me, someone who represents one of the areas where Medicare HMO pullouts were widespread last year, Medicare+Choice has been a mixed bag.

I represent all of San Luis Obispo County and nearly all of Santa Barbara County on California's central coast. Last year all but two HMOs pulled out of San Luis Obispo County, and all but one from the most rural part of that county. The other county, Santa Barbara, was more lucky. None of the HMOs pulled out, but they are threatening to.

In both counties, the providers have complained of low reimbursement rates from HCFA to the HMOs and from the HMOs to the providers. In fact, one of the reasons the HMOs pulled out of northern San Luis Obispo County was because the health care major provider would no longer accept Medicare HMO patients.

So I have some sympathy with the argument that at least in some rural areas the reimbursement rates for HMOs need to be looked at again, and we made that clear, I believe, with the differing testimonies here today.

In my request to HCFA and HHS asking for a review of reimbursement rates for my two counties, I have noted huge disparity of payments to the adjoining jurisdictions. This disparity is not lost on the seniors who receive the benefits.

That said, I am very concerned about the GAO study that claims that Medicare HMOs were paid some $1.3 billion in excess payments in 1998. I find this hard to reconcile with what is happening in my Congressional District.

The issue about HCFA payments apparently is very complex. It is too simple to say that too much money or too little money is going to the plans, but I think there is even a more important lesson we should learn from our experience so far with Medicare+Choice, and we must apply this lesson as we consider any changes to the program, and certainly as any major Medicare reforms are being discussed. That lesson is that Medicare must be a stable program for our seniors.

The upheavals from the HMO pullouts last year really shook up thousands of seniors in my District. I don't want to see this happen again.

It may not be a big deal if my insurance company decides it won't be offering me coverage next year. I'll pick another plan from the list and be slightly inconvenienced. But if I am an 84-year-old senior living on my own, caring for my health is a constant concern, and my HMO dropping me is a life-altering event.

I'm bothered by the cavalier attitude of some who say that these are just routine shake-outs, that things will settle down soon. In

the lives of seniors in my District and across this country, that is a blatant disregard for their lives.

It is not good enough. Seniors in my District felt extreme disruption in their lives of HMO pullouts and they don't want to go through this again.

Finally, I agree with the written testimony of Dr. Berenson, who points out that these disruptions actually underscore the importance of the need for a Medicare reform plan, and particularly including prescription drug coverage as a part of Medicare. That is the reason overwhelmingly that seniors in my District chose the Medicare+Choice.

So let's keep this in mind. Medicare today is an incomplete program without drug coverage. Seniors know that and that is why, as I said, many have chosen Medicare HMOs.

So as we consider how Medicare+Choice is doing, or major reforms to the program like switching to a voucher or premium support plan, let's keep in mind our seniors' need for a stability in the programs that we choose.

Thank you. I'll yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentlelady.

Mr. Pallone for an opening statement?

Mr. PALLONE. Thank you, Mr. Chairman. Again, I want to thank you, also, for holding this hearing.

It is very important that this subcommittee continue to monitor the implementation of the Medicare+Choice program. Although the vast majority of Medicare beneficiaries still receive their care through the traditional fee-for-service option, more and more Medicare beneficiaries are turning to managed care for their health needs and Congress must make sure this program functions as it was intended to function.

I wanted to say, despite the highly publicized decision of 99 HMOs to pull out of their markets or reduce their service area, the evidence to date suggests the program is working. Of the seniors enrolled in Medicare+Choice plans, 95 percent will be able to continue with their plan in the year 2000.

The managed care industry, however, would have us believe something very different. The industry claims its ability to continue providing such benefits is in deep jeopardy because the Federal Government is underpaying Medicare+Choice plans, a phenomena it has dubbed "the fairness gap." The fairness gap seems to me to be nothing more than an attempt the obtain more money from the Federal Government by scaring seniors into believing they are going to lose their benefits.

Let's be clear about one thing: nobody is questioning the ability of Medicare+Choice plans to provide the core benefits package. It is the extra benefits, the ones that are most attractive to seniors, such as prescription drug coverage, that we're talking about. Unfortunately, this distinction is not always clear to seniors, nor is it adequately explained to them by the industry.

An April GAO report of this year found that many factors, not just price considerations, were responsible for the recent withdrawals of managed care plans from the Medicare program. The fact is, this is a good time for the managed care industry. Next year, every

managed care plan that serves Medicare beneficiaries will be paid more than they were this year by an average of 5 percent.

The President's Medicare reform plan, moreover, would provide an incentive for the industry to continue to provide a drug benefit at the same time such a benefit becomes available in the traditional fee-for-service program. Under that plan, HMOs would be reimbursed for about two-thirds of the cost for providing Medicare beneficiaries with a prescription drug benefit.

I'm looking forward today to hearing the industry's views of the President's Medicare reform plan, as well as the White House recently released report on Medicare beneficiaries' access to prescription drugs. That report found that nearly three-fifths of managed care plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. It also found that the proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000.

In sum, the report found that about 75 percent of Medicare beneficiaries lack decent, dependable, private sector coverage for prescription drugs, with one-third having no coverage at all.

In light of these facts, as well as the industry's claim that it is being underpaid by the Federal Government, I would think the industry would be eager to support the President's proposal.

In addition to providing seniors with the prescription drug coverage they need, the net effect of that plan would be an increase in Medicare funding for the industry. If the industry doesn't support this plan, I would be interested to know why.

It seems to me if an HMO is already providing a prescription drug benefit, it could use the money it would get under the President's plan to provide the extra benefits the industry is claiming are in such jeopardy today due to underpayments from the Federal Government.

So, in addition to discussing the status of the Medicare+Choice program, I look forward to also discussing the President's prescription drug proposal. I think elements of that program could help fix some shortcomings that everyone agrees exist and hope we can make some progress in possible solutions to those shortcomings today.

Thank you again, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

I think that completes the opening statements.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

Thank you, Mr. Chairman.

I am pleased that the Health and Environment Subcommittee is holding this hearing today. I believe the Medicare+Choice program stands as one of this Committee's most significant achievements. It is a success because it creates health care options for seniors, while at the same time creating savings to help maintain the solvency of the Medicare program.

Prior to the Balanced Budget Act of 1997, America's seniors were faced with an ailing Medicare program. Just as troubling, Medicare offered its beneficiaries little or no freedom to obtain good, effective coverage.

The Medicare+Choice program changed all that. This program gives seniors access to more choices than ever before, so that they can get better coverage than ever before.

Last year, 99 contracts between health plans and the federal government to participate in the Medicare+Choice program were either terminated or modified to serv-

ice a smaller area. Based on the recent Adjusted Community Rate filings by health plans, it appears once again, there will be 99 contracts terminated or modified for the year 2000. This instability in the program is alarming to me. In 1999, over 400,000 seniors were affected by plan pullouts, over 50,000 were left with no other health plan option. For next year, it is estimated that 327,000 seniors will be affected, with nearly 80,000 seniors left without a health plan option. The real life numbers are even more staggering. Whole families feel the disruption if even one member of that family is affected.

Providing health care to the most vulnerable of our citizens—our seniors—is a serious matter and we must do all we can to ensure stability in their care. If payment levels are the problem, we must look at that. If the cost of bureaucracy is the problem, we must address that. The program must be stable. That is why I am pleased the Subcommittee Chairman called this hearing today—to find out what is happening and to determine what can be done to stabilize the Medicare+Choice program for seniors.

I am also pleased that HCFA is showing some interest in helping plans meet many of the new BBA'97 compliance standards. For instance, their willingness to move the ACR date for this year from May 1 to July 1, and the changes they announced about quality measures is encouraging. It is good for both the plans and the beneficiaries.

I want to reiterate what I said in February that this Committee takes a dim view of regulations that exceed their statutory basis. That is why we will continue formal inquiries by this Committee into this important program and its implementation.

Again, Mr. Chairman, thank you for convening this hearing today. I yield back the balance of my time.

PREPARED STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Thank you, Chairman Bilirakis, for holding this important hearing today. I look forward to hearing from our witnesses about why they believe managed care plans are withdrawing from the Medicare+Choice program in certain regions of the country and what can be done to prevent further defections from the program.

As you know firsthand, Mr. Chairman, the state of Florida is one of the states that will be most impacted by these pull outs—29,000 beneficiaries will be affected. In Lake County, Florida, which is in my district, more than 2,000 beneficiaries participating in Medicare+Choice have been told that the HMO in which they are enrolled has decided to pull out by the end of the year and there is nothing to replace it.

Last year 400,000 beneficiaries nationwide were affected by plans that either altered or terminated their contracts with HCFA. Plans pulled out in large part because of the new requirements for filing adjusted community rates (ACRs) and the uncertainty about the new risk adjustment methodology being proposed by HCFA.

Last February we held a hearing to review the risk-adjuster mandated by Congress to be implemented by the Health Care Financing Administration which was intended to measure the true cost of patient care.

At that same hearing in February several witnesses expressed reservations about HCFA's intent to design a risk adjustment methodology based solely on hospital utilization data because it was felt that it could result in increased and inappropriate hospital use. This would bring with it increased avoidable costs and could harm beneficiaries in plans with enrollees who receive care for expensive chronic illnesses outside the hospital setting.

In addition to implementing its risk adjuster, HCFA has also decided to cut payments to Medicare by $11.2 billion over the next five years. This would be disastrous and it is not what Congress intended. I want to applaud Chairman Bilirakis for introducing H.R. 2419, the Medicare+Choice Risk Adjustment Amendments of 1999, which would require HCFA to implement its risk adjustment process on a budget neutral basis as Congress intended in the 1997 BBA. It would also repeal current law that automatically requires the annual increase in Medicare+Choice payments to be lower than the annual increase in Medicare fee-for-service payments, which has caused HMOs to reduce services. I am pleased to be a cosponsor of this much needed fix to a very misguided policy being pursued by HCFA officials.

Although affected Medicare beneficiaries can switch to the fee-for-service program, I want to work with this Administration to provide these individuals the option of retaining their HMO coverage under Medicare. Offering a choice in health care plans is essential to providing quality care at a reasonable cost.

I believe that most of here in this room do not want to see payments to this program reduced by an additional $11 billion as HCFA seems to be advocating. What we must ensure is that future payments are not ratcheted down by a faulty risk adjustment methodology using skewed data.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Today the Health and Environment Subcommittee will discuss this country's most popular social insurance program, Medicare. I thank Chairman Bliley and Subcommittee Chairman Bilirakis for scheduling a hearing on such a crucial topic.

Since its inception, the Medicare program has provided high-quality health care to our nation's senior citizens and people with disabilities. Once the age group with highest uninsurance rates, seniors today are the only population in our country with nearly universal coverage.

Recently, we made a number of changes to the Medicare program which have introduced new challenges. For example, we must now determine how to provide continuity and stability for seniors when plan participation in Medicare is based on a variety of factors, some of which are beyond the control of the program. Another challenge will be modernizing the program to keep pace with the rapidly changing health care system.

One way to accomplish this goal is to focus our efforts on modernizing the Medicare benefit package for all seniors and people with disabilities. The President's Medicare plan would include a prescription drug benefit for all seniors who chose to enroll, modernize the Medicare fee-for-service program, and extend the life of the Medicare trust fund until 2027 by setting aside nearly 800 billion dollars of the federal surplus. This responsible and equitable proposal would strengthen Medicare well into the next century, so that the 30 million baby boomers who will become beneficiaries over the next few decades can depend on the same program that their parents do today.

I look forward to working with the Committee to ensure that Medicare remains a guaranteed benefit for all seniors and people with disabilities.

Mr. BILIRAKIS. Dr. Robert Berenson is director for the Center for Health Plans and Providers with Health Care Financing Administration.

Dr. Berenson, obviously your written statement is made a part of the record. I will set the clock at 10 minutes. I may have to interrupt you halfway through your presentation because, as you know, we have a series of votes on the floor.

Dr. Berenson?

STATEMENT OF ROBERT A. BERENSON, DIRECTOR, CENTER FOR HEALTH PLANS AND PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION

Mr. BERENSON. I'll try to do my opening statement as quickly as possible to get into the questions.

Chairman Bilirakis, Congressman Brown, distinguished subcommittee members, thank you for inviting me to discuss the Medicare+Choice program.

Despite challenges facing this program, it continues to grow. There are now more enrollees in the Medicare+Choice program than there were before. Some plans made business decisions last year to trim their participation in the program, and I would point to the one chart that I have, which shows that there was, indeed, a drop off representing the withdrawals from last year, but that, indeed, by July there were, in fact, 200,000 more beneficiaries in Medicare+Choice plans than there were before the pull-outs, and hopefully that will happen again in the future.

What doesn't get as much attention is that we are reviewing new applications and service area expansions—and I'll get into more details about that in the Qs and As—but the program does continue to grow.

The vast majority of enrollees are not affected by these plans' decisions to leave Medicare+Choice; nevertheless, we are concerned about the disruption to beneficiaries and have taken steps to ensure that those being forced to change their health insurance coverage are informed of their rights to obtain certain Medigap plans, regardless of preexisting conditions. We also are ensuring that they receive clear information about their health care options.

Many factors affect plan decisions to trim participation in M+C, as the GAO documented in the report released this past April. For instance, plans may have trouble establishing adequate provider networks, enrolling enough beneficiaries to support fixed costs, or otherwise competing in a given market.

Plans withdrawing from Medicare in specific markets often are withdrawing from those same markets in their commercial FEHBP or other business.

Reimbursement to plans does not explain their decisions to trim participation. Payment is rising in all counties by an average of 5 percent for next year, and will rise by as much as 18 percent in some areas.

BBA reforms were designed to increase payment in counties that had the lowest rates, yet counties receiving the largest increases under the BBA payment system are experiencing the most disruption.

In fact, despite BBA reforms, aggregate payments to plans continues to be excessive, according to another GAO report issued in June.

BBA reforms may, however, mean that payments in some counties no longer include enough excess to cover losses in other areas or to subsidize extra benefits that fee-for-service Medicare does not currently cover, especially prescription drugs.

As such, plans are less likely to provide extras like drug coverage without charging premiums. In plans that do offer a drug benefit, its value is declining. Drug coverage by plans is available mostly in high-paid urban areas, which is unfair to rural beneficiaries, who also have the least access to private retiree drug coverage.

Private retiree coverage, itself, is unstable and declining, with now less than a third of the firms offering it, and at least a third of all beneficiaries have no drug coverage at all.

Clearly, all beneficiaries need a more stable and reliable source of prescription drug coverage, and if a plan's primary problem is paying for benefits beyond the Medicare benefit package, the best solution is to provide all beneficiaries with access to an affordable prescription drug benefit and pay plans explicitly for what most now offer in areas where payments are excessive.

That is why it is essential to enact the President's Medicare reform plan. It gives all beneficiaries the option to pay a modest premium for prescription drug benefit. Medicare+Choice plans would be explicitly paid for providing a drug benefit and would no longer have to depend on what the payment rate is in a given area to determine whether they can afford to offer a drug benefit.

The President's plan also would modernize the way Medicare pays managed care plans, overall. Rates would be set through competition among plans, rather than through a complicated statutory formula which causes the kinds of discussions that we've had here so far today.

All plans will be paid their full price through a combination of government and beneficiary payments. The lower the price, the less beneficiaries pay, since the beneficiary contribution rate declines relative to the price of the plan, as in the Federal Employees Health Benefits Program.

The President's plan also will preserve beneficiary options and strengthen protections from plans' withdrawal from Medicare. It will give beneficiaries access to all Medigap plans, regardless of preexisting conditions, including those with prescription drug coverage. It expands the Medigap 6-month open enrollment period to newly disabled beneficiaries and those with end-stage renal disease. It allows beneficiaries with ESRD to enroll in another plan.

These and other changes will strengthen and stabilize the Medicare managed care market. While market volatility must be expected in the private sector, we can and should take steps to stabilize the Medicare+Choice market.

Mr. BILIRAKIS. Doctor, forgive me. I don't think we should be rushing you. What you have to share with us is very important and we're kind of shooting right through it. So we probably only have four votes——

Mr. BERENSON. I'm just finishing up.

Mr. BILIRAKIS. You're finishing up?

Mr. BERENSON. Yes. I'm in my last paragraph.

Mr. BILIRAKIS. Go ahead. Finish it.

Mr. BERENSON. We remain committed to working with plans to facilitate participation in the program, and we look forward to working with Congress to enact the President's Medicare reform proposals.

I thank you again for holding this hearing, and I'm available to answer questions.

[The prepared statement of Robert A. Berenson follows:]

PREPARED STATEMENT OF ROBERT A. BERENSON, DIRECTOR, CENTER FOR HEALTH PLANS & PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION

Chairman Bilirakis, Congressman Brown, distinguished Subcommittee members, thank you for inviting us to discuss the Medicare+Choice program. Despite challenges facing this program, it continues to grow. About 50,000 beneficiaries have enrolled in Medicare+Choice plans each month since January. There are now more enrollees in the program than there were before some plans made business decisions last year to trim their participation in the program. We expect to see continued program growth despite similar decisions by some plans this year.

The vast majority—95%—of Medicare+Choice enrollees are not affected by pending changes in plan participation. Nevertheless, we are concerned about the disruption in service to beneficiaries, particularly to disabled beneficiaries and those who have relied on prescription drug benefits that they may no longer be able to receive. Because of the recent actions by health plans, we have taken steps to ensure that beneficiaries being forced to change their health insurance coverage are informed of their rights to obtain certain Medigap plans regardless of preexisting conditions. We also are ensuring that they receive clear information about their health care options.

Still, the disruptions underscore the importance of the President's Medicare reform plan. It will stabilize the Medicare managed care market by:

- setting plan payment rates through market competition rather than a statutory formula;

- ensuring that all beneficiaries have access to affordable drug coverage;
- paying plans directly for providing drug coverage;
- dedicating a significant portion of the budget surplus to Medicare to help ensure that payment rates will be adequate well into the future; and,
- strengthening protections for beneficiaries when plans withdraw.

BACKGROUND

Medicare+Choice allows private plans to offer beneficiaries a wide range of options, similar to what is available in the private sector today. It requires a massive new beneficiary education campaign to inform beneficiaries about these options. It includes important new protections for patients and providers, as well as statutory requirements for quality assessment and improvement. And it initiates a 5-year transition to a fairer and more accurate payment system.

Medicare+Choice success is a high priority for us. We believe very strongly that private plans are important voluntary options next to original Medicare. Medicare managed care enrollment has tripled under the Clinton Administration, and there are now 6.48 million beneficiaries enrolled in Medicare+Choice plans. We meet regularly with beneficiary advocates, industry representatives, and others to discuss ways to improve the program. We launched a national education campaign and participated in more than 1,000 events around the country to help beneficiaries understand their health plan options. And we are establishing a federal advisory committee to help us better inform beneficiaries about Medicare.

Reductions in Service

Plans make business decisions each year about the extent to which they will continue participation in Medicare+Choice. As of the July 1 deadline for plans to notify us about their participation next year, 99 Medicare+Choice plans will reduce the services they provide as of January 1, 2000. This includes withdrawals from the program by 41 specific plans and cuts in the geographic regions served by another 58 plans. These changes affect about 327,000 beneficiaries in 329 counties in 33 States, or about 5% of all Medicare+Choice enrollees. The total is less than the 407,000 beneficiaries in 407 counties in 29 States who were affected last year. An even smaller number, 79,000 (1.3%), will return to traditional Medicare because the only managed care plan available in their county is leaving. This is more than the 51,000 abandoned enrollees left without access to another managed care plan last year.

As directed by President Clinton in 1998, we will continue to expedite review and approval of plans seeking to enter markets that have been left without a plan. We have approved 41 plans for participation or expansion in the program since last July, and we are reviewing applications to start or expand participation by another 22 plans. Total managed care enrollment this year returned to pre-withdrawal levels within just two months.

Many factors affect plan decisions to trim participation in Medicare+Choice, as was documented in a report released by the General Accounting Office (GAO) in April. For instance, plans may have trouble establishing adequate provider networks, enrolling enough beneficiaries to support fixed costs, or otherwise competing in a given market. Plans withdrawing from Medicare in specific markets often are withdrawing from those same markets in their commercial and other business. For example, Pacificare is withdrawing both Medicare and commercial service in several Washington State counties. And the Federal Employee Health Benefit Plan expects about about 13 percent of plans to withdraw from its program this year, affecting about 1% of its enrollees. There are a disproportionate number of withdrawals this year in rural areas where it is more difficult to maintain provider networks and enrollment level.

Payment Increases

Inadequate reimbursement to plans does not explain plan decisions to trim participation in the program. Payment is rising in all counties this coming year by an average of 5%, and will rise by as much as 18% in some areas. Balanced Budget Act (BBA) payment reforms were designed to increase payment in counties that had the lowest rates and therefore the fewest number of plans. Yet counties receiving the largest increases under the BBA payment system are experiencing the most disruption. Plan withdrawals are affecting 11.1% of enrollees in counties where rates are rising by 10%, but affecting only 2.3% of enrollees where rates are rising by just 2%.

In fact, despite BBA reforms, aggregate payment to plans continues to be excessive, according to another GAO report issued in June. BBA reforms may, however, mean that payments in some counties no longer include enough excess to cover

losses in other areas or to subsidize extra benefits that fee-for-service Medicare does not currently cover, such as prescription drugs.

As such, plans are less likely to provide extras like drug coverage without charging premiums. In plans that do offer a drug benefit, its value is declining. In 1998 only a third of plans capped drug coverage below $1000, but next year nearly three fifths will, and more than one fourth will cap coverage below $500. Drug coverage by plans is available mostly in high-paid urban areas, which is unfair to rural beneficiaries who also have the least access to private retiree drug coverage. Private retiree coverage itself is unstable and declining, with now less than a third of firms offering it. And at least a third of all beneficiaries have no drug coverage at all.

Clearly all beneficiaries need a more stable and reliable source of prescription drug coverage. And, if plans' primary problem is paying for benefits beyond the Medicare benefit package, the best solution is to improve the benefit package by providing all beneficiaries with access to an affordable prescription drug benefit, and paying plans explicitly for what most now offer only in areas where payments are excessive.

The President's Reform Plan

That is why it is essential to enact the President's Medicare reform plan. It gives all beneficiaries the option to pay a modest premium for a prescription drug benefit. This benefit will cover half of all prescription drug costs up to $5,000 when fully phased in, with no deductible—all for a modest premium that will be less than half the price of the average private Medigap policy.

Medicare+Choice plans would be explicitly paid for providing a drug benefit under the President's plan. They would no longer have to depend on what the rate is in a given area to determine whether they can offer to do so.

The President's plan also will modernize the way Medicare pays managed care plans. Rates would be set through competition among plans rather than through a complicated statutory formula, as they are today. All plans would be paid their full price through a combination of government and beneficiary payments. The lower the price, the less beneficiaries pay since the beneficiary contribution rate declines relative to the price of the plan, as in the Federal Employees' Health Benefits Program. Beneficiaries choosing plans that cost approximately 80% of traditional fee-for-service will pay no Part B premium.

The President's plan also will preserve beneficiary options and strengthen protections when plans withdraw from Medicare by:

- giving beneficiaries access to all Medigap plans regardless of preexisting conditions, including those with prescription drug coverage;
- expanding the Medigap 6-month open enrollment period to newly disabled beneficiaries and those with end stage renal disease;
- allowing beneficiaries with end stage renal disease to enroll in another plan;
- mandating a special one-time additional Medigap open enrollment period for beneficiaries who were affected by a plan termination last fall; and
- increasing civil monetary penalties of up to $50,000 per violation plus $5,000 per day per violation of the Medigap open enrollment requirements.

All these changes will strengthen and stabilize the Medicare managed care market.

The President's plan also dedicates 15 percent of the budget surplus to Medicare for the next 15 years. This will assure the financial health of the Medicare Trust Fund through at least 2027, and help ensure that Medicare+Choice plan payment rates will be adequate well into the future.

Encouraging Plan Participation

To assist plans, we worked with Congress to give plans two more months to file the information used to approve benefit and premium structures. We allowed plans to submit this "Adjusted Community Rate" data on July 1, rather than May 1, so plans were able to use more current experience when designing benefit packages and setting cost sharing levels. July 1 is the latest we can accept, process, and approve premium and benefit package data, have the data validated, and still mail beneficiaries information about available plans in time for the November open enrollment.

To further encourage plan participation, we have worked with plans to minimize the administrative workload associated with participating in Medicare+Choice. In February, we published initial refinements to the Medicare+Choice regulation that improve beneficiary protections and access to information while making it easier for health plans to offer more options to beneficiaries. The new rule:

- clarifies that beneficiaries in a plan that leaves the program are entitled to enroll in remaining locally available plans;

- specifies that changes in plan rules must be made by October 15 so beneficiaries have information they need to make an informed choice during the November open enrollment;
- allows plans to choose how to conduct the initial health assessment;
- waives the mandatory health assessment within 90 days of enrollment for commercial enrollees who choose the same insurer's Medicare+Choice plan when they turn 65, and for enrollees who keep the same primary care provider when switching plans;
- stipulates that the coordination of care function can be performed by a range of qualified health care professionals, and is not limited to primary care providers;
- limits the applicability of provider participation requirements to physicians; and,
- allows plans to terminate specialists with the same process for terminating other providers.

We intend to publish a comprehensive final rule with further refinements this fall.

BBA Payment Reforms

While the President's reform plan will use competition to set plan payment rates, the BBA initiated other important payment reforms that are already underway. The BBA begins to break the link between managed care and fee-for-service rates. And, starting in January, the BBA mandates that we "risk adjust" payments to account for the health status of each enrollee.

Under the BBA system, a rate for a particular county is the greater of three possible rates: a new minimum or "floor" payment; a minimum 2% increase over the previous year's rate, or a blend of the county rate and an input price adjusted national rate. The new system is phased in over five years, and therefore has several different moving parts. Medical education costs, which had been included in HMO payments under the old system, are paid instead directly to teaching hospitals. The blend of county and national rates phases up to a 50/50 balance. The national rate, local rates and minimum payment amount are annually updated based on per capita Medicare cost growth. As mentioned above, payments will increase an average of 5% for next year.

The BBA also established a competitive pricing demonstration in which plan payment rates will be set through a bidding process, similar to what most employers and unions use to decide how much to pay plans. To ensure broad community involvement in this project, a Medicare Competitive Pricing Advisory Commission, chaired by General Motors Health Care Initiative Executive Director James Cubbin, has made recommendations regarding key design features. It also has selected the markets of Phoenix, Arizona and Kansas City, Kansas and Missouri, as initial demonstration sites. We established local advisory committees in these communities and, at their request, the national advisory commission agreed to delay implementation for one year in order to ensure adequate time for all parties to prepare for this essential project.

There is considerable evidence that we have overpaid and continue to overpay plans. That is because payments are linked to local fee-for-service spending and not adjusted for risk, according to studies by the Congressional Budget Office, Physician Payment Review Commission, Mathematica Policy Research, and many others. As mentioned previously, a GAO report released this June documents that, despite BBA reforms, plans are still being paid more than it costs them to provide the Medicare covered services that they are required to provide. The GAO says excess payments to plans totaled $1.3 billion in 1998, and will increase each year because of a forecasting error that the BBA locked in the statutory payment formula.

Payment to plans will be more accurate with risk adjustment. Data on each individual beneficiary use of health care services in a given year will be used to adjust payment for that beneficiary the following year. Risk adjustment helps assure that payments are more appropriate, and curtails the disincentive to enroll sicker beneficiaries.

The law does not call for a transition to risk adjustment, but we believe incremental implementation will prevent disruptions to beneficiaries or the Medicare+Choice program. We are therefore using flexibility afforded to us in the law to phase in risk adjustment over five years. In the first year, only 10% of payment to plans for each beneficiary will be based on the new risk adjustment method, which for the time being is based only on inpatient data. By 2004, we will be able to use data from all sites of care for risk adjustment. Then, and only then, will payment to plans be 100% based on risk adjustment. In the meantime, even with its limitations, the initial risk adjustment system based on inpatient data alone will increase payment accuracy 5-fold.

It is essential to stress that risk adjustment will not and cannot be budget neutral. The whole reason for proceeding with risk adjustment is that Medicare has not been paying plans accurately. Congress also recognized that plans have been paid too little for enrollees with costly conditions, and too much for those with minimal care needs. The vast majority of beneficiaries enrolled in Medicare+Choice cost far less than what Medicare pays plans for each enrollee.

Medicare fee-for-service statistics make clear why risk adjustment should not be budget neutral. More than half of all Medicare fee-for-service beneficiaries cost less than $500 per year, while less than 5% of fee-for-service beneficiaries cost more than $25,000 per year, according to the latest available statistics for calendar year 1996. The most costly 5% account for more than half of all Medicare fee-for-service spending.

Since Medicare+Choice enrollees tend to be healthier than fee-for-service Medicare beneficiaries, the ratio of high to low cost beneficiaries in health plans is even more stark. Clearly, care for the overwhelming majority of Medicare enrollees cost plans much less than what Medicare pays because our payments are predicated on the average beneficiary cost of care, calculated by county. This average includes the most expensive beneficiaries in fee-for-service, who generally do not enroll in managed care.

Budget neutral risk adjustment would mean Medicare and the taxpayers who fund it would continue to lose billions of dollars each year on Medicare+Choice. Budget neutral risk adjustment would cost taxpayers an estimated $200 million in the first year of the phase-in, and $11.2 billion over five years if health plans maintained their current, mostly healthy beneficiary mix. Actual savings to taxpayers from risk adjustment will vary to the extent that less healthy beneficiaries enroll in Medicare+Choice plans, resulting in higher payments than health plans receive today.

The amount of payment change will vary among plans and depend on each plan's individual enrollees. Overall, we project that payment on average will change by less than 1% in the first year. How it will change over time depends on the mix of beneficiaries in each plan. Risk adjustment significantly changes incentives for plans and could well lead to enrollment of beneficiaries with greater care needs who could benefit most from managed care. That could result in plans receiving higher payments. Phasing in risk adjustment also substantially buffers the financial impact. Taxpayers are forgoing $1.4 billion in the first year and up to $4.5 billion over the full five years because of the phase in.

Beneficiary Education

We are working to help beneficiaries affected by plan withdrawals move to other plans or back to traditional Medicare. We are working diligently to make sure beneficiaries affected by plan terminations and service area reductions know about their rights and options. We are providing plans with a model letter that meets the requirement that they send all affected beneficiaries an information package by September 15, 1999. This information should explain options to return to fee-for-service Medicare with supplemental coverage or to enroll in another Medicare HMO. We review and approve all materials sent by plans to beneficiaries to ensure that they are accurate.

All beneficiaries have the option of returning to original fee-for-service Medicare. Most beneficiaries also have the option of enrolling in another Medicare HMO where they live. If beneficiaries take no action, they will automatically return to original fee-for-service Medicare on Jan. 1, 2000. If they return to fee-for-service Medicare before December 31, they may lose important rights to supplemental Medigap coverage.

For example, beneficiaries who remain in a withdrawing plan until December 31 are guaranteed the right to buy any Medigap plan designated A, B, C, or F available in their state until March 3, 2000. If they apply for one of these Medigap policies no later than March 3, companies selling the policies cannot place limits or discriminate in price because of beneficiary preexisting conditions. These protections are not guaranteed if beneficiaries disenroll before December 31, 1999 which, as mentioned above, is a policy that the President's Medicare reform plan will change.

Help in understanding such rights and options, as well as up-to-date information about other Medicare+Choice plans available in a given county, is available at 1-800-MEDICARE (1-800-633-4227), at 1-877-486-2048 for the hearing impaired, and on the Medicare Compare web page at www.medicare.gov. Many libraries and senior centers can help beneficiaries obtain Medicare information from the Internet. Beneficiaries also can contact their State Health Insurance Assistance Program for assistance. And many other groups provide information about Medicare, including the

AARP, local Area Agency on Aging offices, National Rural Health Association, Social Security Administration and HCFA regional offices.

We are also working diligently to educate all beneficiaries about the Medicare+Choice program. We launched the National Medicare Education Program to make sure beneficiaries receive accurate, unbiased information about their benefits, rights, and options. The campaign includes:

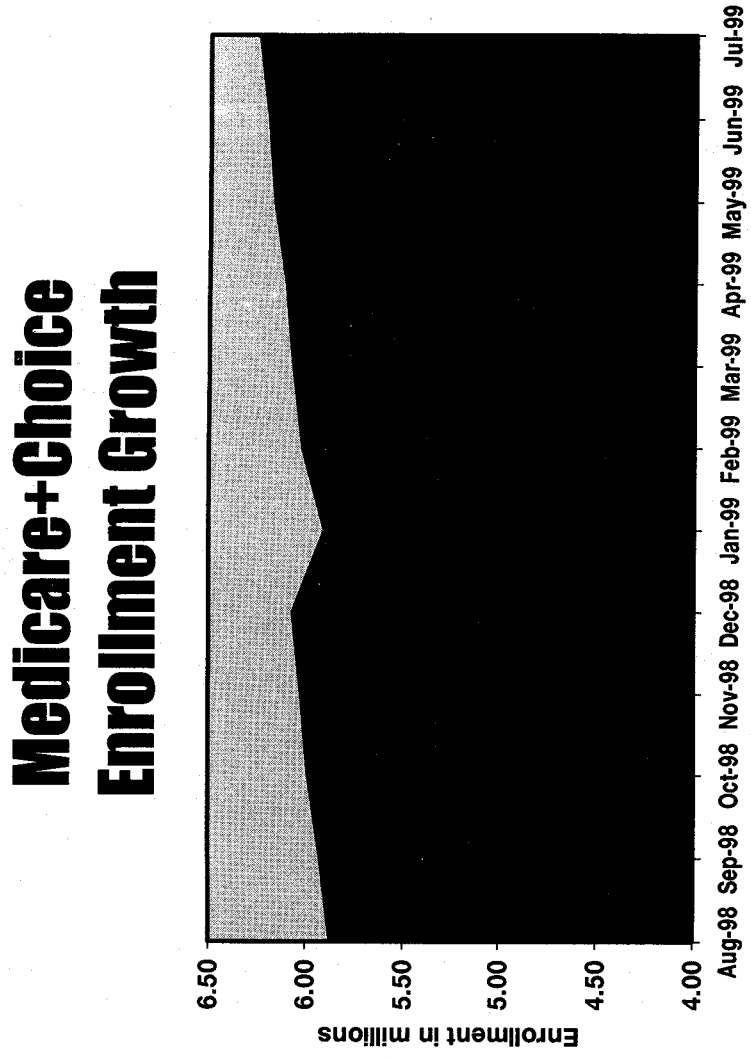
- mailing a *Medicare & You* handbook to explain health plan options;
- a toll-free "1-800-MEDICARE" [1-800-633-4227] call center with live operators to answer questions, and provide detailed plan-level information;
- a consumer-friendly Internet site, www.medicare.gov, which includes comparisons of benefits, costs, quality, and satisfaction ratings for plans available in each zip code;
- working with more than 120 national aging, consumer, provider, employer, union, and other organizations who help disseminate information to their constituencies;
- beneficiary counseling from State Health Insurance Assistance Programs;
- a national publicity campaign;
- a Regional Education About Choices in Healthcare (REACH) campaign that will conduct State and local outreach activities nationwide; and,
- a comprehensive assessment of these efforts.

We tested the system in five States in 1998 and learned how to improve efforts for this November's open enrollment period. For example, we have made the Medicare & You handbook easier to use and improve the accuracy of information about plans that are withdrawing. We have added new links on our Medicare Compare website at www.medicare.gov to help users find information faster. We are standardizing plan marketing materials that summarize benefits so beneficiaries can more easily make apples-to-apples comparisons among plans in this November's open enrollment period. And we have added information on managed care plan withdrawals to the Important Notes section of the 1999 plan information on our Medicare Compare website.

To help us continually improve our education efforts, we are establishing the Citizens' Advisory Panel on Medicare Education, under the Federal Advisory Committee Act. The panel will help enhance our effectiveness in informing beneficiaries through use of public-private partnerships, expand outreach to vulnerable and underserved communities, and assemble an information base of "best practices" for helping beneficiaries evaluate plan options and strengthening community assistance infrastructure. Panel members will include representatives from the general public, older Americans, specific disease and disability groups, minority communities, health communicators, researchers, plans, providers, and other groups.

CONCLUSION

While market volatility must be expected in the private sector, we are concerned about the message being sent to beneficiaries about the reliability of Medicare+Choice plans. In fact, among beneficiaries affected by plan service reductions last year, half of those who could have chosen another managed care plan instead chose to return to the original fee-for-service Medicare program. Nonetheless, we remain committed to working with plans to facilitate participation in the program. And we look forward to working with Congress to enact the President's Medicare reform proposals that will increase protections for beneficiaries when plans withdraw from the program, ensure that plans receive full payment of market-based rates, and guarantee that all beneficiaries have access to affordable prescription drug coverage. I thank you again for holding this hearing, and I am happy to answer your questions.


Medicare+Choice
Enrollment Growth
Enrollment in millions
6.50
6.00
5.50
5.00
4.50
4.00
Aug-98
Sep-98
Oct-98
Nov-98
Dec-98
Jan-99
Feb-99
Mar-99
Apr-99
May-99
Jun-99
Jul-99

Mr. BILIRAKIS. Thank you very much, Doctor.

We will break. We have at least two votes. Just as soon as we are able to get back, we'll continue.

Mr. BERENSON. Thank you.

[Brief recess.]

Mr. BILIRAKIS. The committee will come to order.

Thank you, Dr. Berenson, for your testimony, and also for your patience and understanding.

Dr. Berenson, I think—and I would hope that you agree—that the intent of the legislature, the intent of Congress is to be taken very seriously.

As far as you know, was there any doubt in the minds of HCFA as to what was intended by the Congress in BBA in 1997 in terms of the risk adjustor and remaining neutral?

Mr. BERENSON. Yes, I think we actually do have a different view of what was intended. In fact, just recently this issue came up about the intent of Congress regarding risk adjustment and budget neutrality—I wasn't around at the time, but people went back into the files and into the record and we found a report from the CBO dated November 12, 1997, entitled, "Medicare+Choice Provisions in the Balanced Budget Act," and on page 13 it says, "Adding a health status adjustor can further reduce capitation rates relative to per capita fee-for-service cost. The size of the additional reduction would depend on the extent of the selection bias and the risk sector when the new adjustor is put in place how effectively the adjustor accounts for the selection."

We think that's a CBO analysis that at that time understood that the risk adjustor might result in decreased payments to the plans.

Our understanding was that it wasn't scored as a savings because there was some question about our ability to implement the risk adjustor on time and they weren't sure what the details would be.

But I think we don't agree that the intent was for budget neutrality in risk adjustment.

Mr. BILIRAKIS. Well, Congress now needs to share with HCFA its intent and clarify that—and I agree with you that maybe it wasn't all that clear. Although CBO has testified in a hearing before the Senate Committee on Finance on June 9 of this year—a statement by Steve Lieberman, Executive Associate Director of the Office of Director of CBO—I would ask unanimous consent this might be put in the record and, without objection, that will be the case—they have stated on page 6 of that, "Until 1999, CBO had assumed that Medicare+Choice payments would be adjusted for risk without changing total outlays." And the total outlays that are envisioned by HCFA, as I understand it, are in the category of $11 billion in savings.

[The prepared statement by Steven M. Lieberman follows:]

PREPARED STATEMENT OF STEVEN M. LIEBERMAN, EXECUTIVE ASSOCIATE DIRECTOR, OFFICE OF THE DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. Chairman, Senator Moynihan, and Members of the Committee, it's a pleasure to appear before you today to discuss the enrollment and payment issues confronting the Medicare+Choice program. The growth in that program's enrollment is closely linked to the adequacy and appropriateness of Medicare's capitaled payments.

The recent withdrawal of plans from Medicare+Choice, coupled with reduced growth in payments, has prompted some observers to worry about the future of the Medicare+Choice program.

My testimony discusses the Congressional Budget Office's (CBO's) projection of enrollment in Medicare+Choice plans over the next 10 years and the factors influencing growth in that enrollment. Financial incentives play a critical role in determining whether plans participate in Medicare+Choice, whether beneficiaries enroll, and whether providers deliver appropriate services in an efficient manner.

For Medicare+Choice to be a viable program, beneficiaries must have incentives to relinquish traditional fee-for-service and enroll instead in competing health plans. The challenge is to have a system that yields greater returns when it efficiently provides necessary, high-quality services and smaller returns when it provides inefficient, low-quality, or unnecessary services. Meeting that challenge requires that plans, providers, and beneficiaries each bear some degree of financial risk. Serious problems can result if Medicare payments do not bear a reasonable relationship to the costs of care for each group of beneficiaries for which plans and providers accept risk. Payments to providers must be fair and, ideally, give incentives to control costs while rewarding quality.

If consumers have a choice of health plans offering various combinations of benefits and premiums, they can select the plan that best meets their needs. Enrollment in Medicare+Choice plans would grow if those plans offered better benefits or lower costs than traditional Medicare. If consumers have no choice of plans or if those plans offer unattractive benefits, high costs, or poor quality, beneficiaries will remain in fee-for-service Medicare.

ENROLLMENT IN THE MEDICARE+CHOICE PROGRAM

CBO projects that growth in Medicare+Choice enrollment will average 9 percent annually between 1999 and 2009. Though quite rapid, that rate of increase represents a sharp reduction from earlier trends.

The Balanced Budget Act of 1997 (BBA) established Medicare+Choice and changed payment provisions for both health maintenance organizations (HMOs) and fee-for-service providers. CBO had assumed that Medicare+Choice enrollment would continue to grow at the dramatic rates of the program it replaced. The annual rate of growth in enrollment in Medicare's risk-based plans peaked at 36 percent in fiscal year 1996, however, and slowed in subsequent years. CBO projects that 31 percent of all Medicare beneficiaries will join Medicare+Choice plans in 2009, up from 16 percent this year (see Table 1).

TABLE 1. ACTUAL AND PROJECTED ENROLLMENT IN RISK-BASED HMO PLANS AND MEDICARE+CHOICE

Fiscal Year	Enrollees		
	Number (Millions)	Percentage of Medicare Beneficiaries	Annual Growth in (Enrollment Percent)
Actual			
1992	1.4	4.0	n.a.
1993	1.6	4.5	13.8
1994	1.9	5.2	18.9
1995	2.5	6.7	29.7
1996	3.4	8.9	36.0
1997	4.5	11.7	32.4
1998	5.5	14.1	22.2
1999	6.2	15.7	12.7
Projected			
2000	6.6	16.6	6.5
2001	7.1	17.7	7.6
2002	7.6	18.7	7.0
2003	8.4	20.4	10.5
2004	9.2	22.0	9.5
2005	10.1	23.8	9.8
2006	11.1	25.6	8.9
2007	12.0	27.4	9.1
2008	13.1	29.3	9.2

TABLE 1. ACTUAL AND PROJECTED ENROLLMENT IN RISK-BASED HMO PLANS AND MEDICARE+CHOICE—Continued

Fiscal Year	Enrollees		
	Number (Millions)	Percentage of Medicare Beneficiaries	Annual Growth in (Enrollment Percent)
2009	14.1	30.9	7.6

SOURCE: Congresional Budget Office.
NOTE: HMO=health maintenance organization; n.a.=not applicable.

HMO Withdrawals

Last year, 99 HMOs announced they were either terminating or, far more commonly, scaling back their Medicare+Choice operations in certain counties. The potential disruption involved 407,000 enrollees, accounting for 7 percent of all Medicare+Choice enrollment. Plan withdrawals occurred in 406 counties—42 percent of the counties covered by Medicare managed care. Nonetheless, the overwhelming majority of the affected beneficiaries had the option to switch to a competing Medicare+Choice plan.

The unanticipated withdrawal of plans from the Medicare market has heightened awareness that plans can leave the market. That perception is likely to reduce the willingness of some Medicare beneficiaries to enroll in plans in the next few years. Although the effects of plans' withdrawal on Medicare+Choice enrollment seem relatively clear, explaining why plans withdrew appears more controversial.

In a recent report, the General Accounting Office concluded that most likely more than one factor was responsible for the withdrawals.

> No one factor can explain why plans choose to participate in particular counties. Although plans obviously consider payment rates, many other factors also influence their business decisions.
>
> The current movement of plans in and out of Medicare may be primarily the normal reaction of plans to market competition and conditions . . . Other factors associated with plan withdrawals—recent entry in the county, low enrollment, and higher levels of competition—suggest that a number of Medicare plans withdrew from markets in which they had difficulty competing.

By contrast, the HMO trade group, the American Association of Health Plans (AAHP), attributes the withdrawals to inadequate payment rates, exacerbated by the administrative burdens imposed by the Health Care Financing Administration's (HCFA's) "MegaReg" for implementing the BBA's provisions. AAHP believes that without substantial revisions to Medicare+Choice, additional plans will withdraw from the program.

Adverse publicity associated with the health plans' withdrawal from Medicare+Choice is likely to temporarily slow growth in enrollment. But over the longer term, that growth depends critically on the size of payment increases and the ability of plans to offer attractive additional benefits, such as prescription drugs.

Constraining Medicare+Choice Payments

Health plans, as businesses, will participate in Medicare+Choice markets only if they have an expectation of an adequate return—at a minimum, if they can reasonably expect at least to cover costs. If payments are perceived as being inadequate, health plans will tend not to participate in Medicare+Choice, especially if they foresee little prospect of Medicare payments becoming adequate.

A similar dynamic applies to providers. Regardless of mission or not-for-profit status, physicians and other providers cannot afford to participate indefinitely when their enterprises are losing money.

In addition to causing plans to withdraw, inadequate Medicare+Choice payments have another, compounding effect on enrollment growth. Reducing payment increases to Medicare+Choice plans will impede their ability to offer extra benefits or limit beneficiary cost sharing. Taking steps such as eliminating prescription drug benefits or requiring hefty monthly premiums instead of "zero premiums" will make Medicare+Choice plans less attractive to consumers. As a result, fewer beneficiaries will choose to join those plans.

Are Medicare+Choice payments inadequate? The adequacy of payments can be evaluated from five often-competing perspectives.

- Are plans able to provide appropriate services while remaining financially stable?
- Are payments fair, permitting (if not encouraging) plans and providers to serve sicker patients?

- Is there an adequate choice of health plans in both urban and rural parts of the country?
- Do the payments offered by Medicare+Choice plans attract physicians, hospitals, and other providers to participate in their networks?
- Do the payments help keep Medicare affordable for both beneficiaries and taxpayers?

Having well-established plans "vote with their feet" and withdraw from their key Medicare+Choice markets is an indication that payment and other conditions of participating in Medicare+Choice may be too stringent. But health plans have powerful incentives to convince policymakers that Medicare+Choice payments need to be increased without having to withdraw from the program.

CHANGES TO MEDICARE+CHOICE PAYMENTS UNDER THE BALANCED BUDGET ACT

The BBA enacted six policies that affected Medicare+Choice payments.

- The BBA significantly reduces fee-for-service spending, which also slows the growth of payments to health plans because annual updates to Medicare+Choice payment rates are tied to the growth in per-enrollee spending in the traditional Medicare program.
- The BBA sets the annual increases in Medicare+Choice payment rates below the growth in fee-for-service spending from 1998 through 2002.
- The portion of Medicare+Choice payment rates that is attributable to fee-for-service spending for graduate medical education will be gradually eliminated.
- HCFA will withhold about 0.2 percent of payments to Medicare+Choice plans to pay for dissemination of information to beneficiaries about their coverage options.
- A blend of local and national payment rates will be phased in for Medicare+Choice plans. That blending provision redistributes money from areas with high payment rates to those with low payment rates.
- New payment risk adjusters will be implemented in two stages. Those adjusters are intended to more accurately reflect the expected costs of providing health care to enrollees in Medicare+Choice plans.

The first four policies were enacted with the expectation that they would slow the growth of Medicare spending. Those policies reduce the cumulative growth in Medicare+Choice payment rates relative to fee-for-service payments by 6 percent. The blending of local and national payment rates is purely redistributive, but particular counties will see substantial changes in payment rates. The new risk adjusters were not necessarily expected to lower average payments to Medicare+Choice plans but, as discussed below, they could yield substantial program savings when they are implemented.

Impact of the Payment Blend

Because of the blending of national and local payment rates, payment increases are projected to vary enormously from county to county. For example, some counties would experience such large increases in payment rates from 1997 to 2000 that the theoretically available Medicare+Choice payment rates—if any plans operated in the areas—would exceed 180 percent of the 1997 (pre-BBA) payment rates. In contrast, some counties with high payment rates would see only a 6.1 percent increase in their rates over the same period.

Historically, both the level of and increase in Medicare spending per beneficiary varied dramatically in different counties. HCFA, however, no longer produces those data on county-specific spending trends. If past trends continue, some Medicare+Choice plans will face payment rates that are projected to be substantially below both per capita fee-for-service spending and 1997 (pre-BBA) amounts.

Over half (52) of the 100 counties with the most Medicare+Choice enrollees are projected to have payment rates fall by 5 percent or more using as the standard of comparison the rates that Medicare would have paid if 1997 payments were increased by the national average growth in per capita fee-for-service spending and the BBA payment provisions were fully in effect. Using that methodology, the steepest reduction is estimated to be 12 percent. In the top 100 counties, 88—home to 78 percent of the enrollees—would experience declines in payment rates, compared with 1997 rates. These estimates do not include the lower payments resulting from HCFA's implementation of risk adjustment.

Impact of Risk Adjustment

Until 1999, CBO had assumed that Medicare+Choice payments would be adjusted for risk without changing total outlays. In January, the Administration published plans to phase in risk adjustment in a manner that would reduce payment rates for enrollees in Medicare+Choice plans. The first stage of risk adjustment would be

based on the use of impatient hospital services by individual enrollees. That change would reduce payments for existing enrollees by 7.6 percent when fully phased in—by 2004. The Administration also announced a second stage of risk adjustment that would be based on use of services in all settings. The Administration expects that such an adjustment would reduce payments by another 7.5 percent, beginning in 2004. If both plans are implemented as announced, the combined effect could reduce payments by about 15 percent.

Payment reductions related to risk adjustment on the order of 15 percent would be likely to cause plans to drop out of the program and enrollment in Medicare+Choice to drop sharply. Because of the magnitude of the planned reduction and the discretion retained by the Administration in implementing the adjusters, the CBO baseline does not assume the full savings from risk adjustment. For the same reason, the projections of Medicare+Choice enrollment discussed in my testimony today explicitly do not reflect the full savings. Instead, CBO assumes that risk adjustments will ultimately reduce payments by lesser amounts.

RISK SELECTION AND RISK ADJUSTMENT

Risk selection occurs when groups of beneficiaries, such as those who enroll in a Medicare+Choice plan, have average costs that are systematically different from the average costs of beneficiaries who are treated as similar by the risk adjuster. When monthly payments are made on a fixed, prospective (or capitaled) basis, those groups of enrollees are referred to as "risk pools." If Medicare+Choice enrollees tend to have lower costs than comparable fee-for-service beneficiaries, the result is known as "favorable" risk selection. Conversely, "adverse" risk selection occurs when groups or risk pools have costs that are higher than those of comparable fee-for-service beneficiaries.

Risk selection is incompletely understood and imperfectly measured. It can arise from many different sources. If unchecked, risk selection can destroy an insurance system. Systematically selecting people who are healthier than average pays off handsomely: the returns on favorable selection can overwhelm any potential savings from operating an efficient system for managing care. Health insurance systems in which biased selection segments the risk pool are said to enter a "death spiral" if the problem is not fixed.

One goal of risk adjustment is to pay more fairly. In a fair system, the amounts paid for different risk pools would closely approximate the average cost of providing services to their members. Under that framework, a good risk adjuster would pay groups with sicker, more expensive people proportionately more and groups with healthier, less expensive beneficiaries proportionately less.

Medicare+Choice Risk Adjuster

There are a wide variety of potential approaches to mitigating the effects of risk selection. HCFA has adopted a mechanism for risk adjustment that relies on impatient hospital admissions for specific diagnoses to trigger higher capitaled payments in the following year. That mechanism, which is known as the principal in-patient/diagnostic cost group (or PIP/DCG), attempts to adjust payments statistically to account for individuals with persistently high costs. On average, PIP/DCGs would reduce payments somewhat for most beneficiaries but increase them significantly for the minority of beneficiaries who were hospitalized in the prior year for specific conditions (such as congestive heart failure).

HCFA has had to overcome significant analytical and operational obstacles in setting up the PIP/DCG system. The agency appears to be successfully implementing that complex system, for which it deserves recognition. But it is important to understand the limitations of that system for adjusting payments.

Developing a Medicare Risk Adjuster

Although the PIP/DCG system is a significant improvement over demographic adjusters, it has had limited success in achieving the goal of "fair" payments—payments that are closely related to the costliness of beneficiaries (based on their health status). Two factors contribute to the difficulty of developing an adequate Medicare risk adjuster.

First, the health care costs for individuals are enormously difficult to predict. That difficulty is compounded when the predictions are based on the administrative data available from processing claims.

Second, Medicare spending is extremely skewed—that is, the sickest beneficiaries are extraordinarily costly. The most expensive 5 percent of Medicare beneficiaries cost almost as much as the remaining 95 percent of all Medicare beneficiaries. On average, those in the top 5 percent cost over $70,000 annually—more than 10 times the average annual cost for all Medicare beneficiaries.

The variation in cost per beneficiary has two critically important implications. On the one hand, it highlights the potential financial consequences associated with both risk selection and inadequate risk adjustment. On the other hand, assuming neutral risk selection—that a risk pool has an "average" population—the skewness of the distribution of costs may require relatively large numbers of participants for a risk pool to be stable. Very large risk pools are unlikely to be undermined by having one too many—or too few—million-dollar cases in a year. Small risk pools, however, could be seriously disrupted by having just one person who incurs catastrophic health care costs.

Large health plans may be able to assume full financial risk for their enrollees. Even without risk selection, small plans may not be well positioned to assume full financial risk. In many large Medicare+Choice markets, health plans base payments to physicians or other providers on a percentage of premiums, thereby passing risk on to the providers.

These compensation arrangements do not directly connect HCFA to provider payments. Yet HCFA remains vitally involved for two reasons. First, HCFA regulates the terms and conditions under which physicians may be placed at substantial financial risk, approving their contracts with Medicare+Choice plans. Second, HCFA has a vital interest in and regulatory responsibility for assuring that beneficiaries have adequate access to sufficient providers and receive high-quality care.

The numerous Medicare+Choice providers who are paid on a capitaled, percentage-of-premium basis subdivide a health plan's risk pool. As a result, even relatively large risk pools at the health plan level may become too small at the provider level. PIP/DCGs may not be a desirable system for adjusting payments to small risk pools.

Problems with Using an Inpatient Risk Adjuster

The first phase of the PIP/DCG relies solely on impatient hospital admissions and excludes care delivered in other settings. One can argue that the reliance on impatient hospital admissions hurts managed care plans, many of which have reduced their use of impatient hospital services. Some plans have implemented effective disease management and other protocols that may alter the pattern of care, possibly minimizing the specific admissions that are rewarded by the PIP/DCG methodology.

What are the implications of the impatient PIP/DCG payment system for a Medicare+Choice plan that has invested in developing sophisticated disease management systems for chronic conditions? Unlike acute episodes of care, chronic conditions, such as congestive heart failure, can frequently have high and recurring costs. Paradoxically, that makes such conditions ideal for both disease management interventions and for creating a PIP/DCG payment adjustment.

With chronic conditions, an HMO can identify who is at risk and develop intervention strategies to improve outcomes. Typically, successful interventions stress prevention, investing in patients' education, and gaining their compliance with protocols. Although such strategies do not "cure" chronic conditions, they improve patients' outcomes and frequently save money by avoiding hospitalizations. Success in avoiding hospitalizations, however, means that the Medicare+Choice payment rate is never increased to compensate for the beneficiary with high-cost, chronic conditions. Without a hospitalization for congestive heart failure, for example, the PIP/DCG system does not recognize that the beneficiary has the condition.

Is this "Catch 22" real? Preliminary findings from an analysis being conducted by John Bertko, a principal in the actuarial consulting inn of Redden & Anders, provide some guidance. A highly sophisticated Medicare+Choice plan appears to have implemented effective disease management protocols for several conditions, including congestive heart failure. By investing about $3,000 annually in each patient, that HMO has apparently managed to avoid about half the expected hospital impatient admissions for congestive heart failure. Such an HMO could become the victim of its own success in managing care. In cases in which a beneficiary with congestive heart failure avoids hospitalization because of better medical management, for example, the HMO would forgo over $12,000 in higher PIP/DCG payments in the subsequent year if the system was fully phased in. Not only would the HMO's success in avoiding hospitalization preclude its receiving the higher revenues, but the plan would also have incurred higher expenses to finance the disease management program.

These findings are preliminary. But even if the completed analysis confirms the initial findings, it is unclear how many Medicare+Choice plans have the sophistication to implement comparable programs. It is also unclear how many conditions would be susceptible to disease management interventions that avoided hospitalizations that trigger higher PIP/DCG payments. However, sophisticated disease management programs for conditions such as diabetes with complications or chronic obstructive pulmonary disease might generate similar "Catch 22s."

Problems with Refining PIP/DCGs

The successful development of the second stage of PIP/DCG risk adjusters faces formidable obstacles. Relying on hospital impatient data means that the data sets are, compared with the total volume of Medicare claims, relatively manageable. Expanding the adjustment system to include outpatient procedures markedly increases the number of claims to be analyzed. Including all Medicare services could further increase the number of claims by an order of magnitude. Simply manipulating the data will pose significant challenges.

Hospitals have long had strong incentives to precisely code impatient admissions, making the claims and diagnostic information relatively reliable. HCFA may encounter significant problems with the reliability and validity of some of the data that would be used in the second stage of PIP/DCGs. The accuracy of hospital outpatient data, for example, might prove problematic for use in the more comprehensive risk-adjustment system.

ALTERNATIVE APPROACHES TO RISK ADJUSTMENT

The discussion earlier in my testimony highlighted some of the problems associated with devising and improving an adequate mechanism for adjusting payments for risk. HCFA and others have funded extensive research in efforts to develop viable mechanisms. The inability to devise more effective tools underscores how difficult the challenge actually is.

An alternative to using a statistical approach to adjust payments is to alter the level of risk borne in the payment pool. Some payers, such as state Medicaid agencies, are using a variety of approaches that, in effect, adjust the risk pool, not the payments.

Under fee-for-service, physicians and other providers can be viewed as revenue centers: the more services they provide and bill, the more they get paid. That arrangement provides strong incentives to use more, rather than fewer, services. In stark contrast, under capitaled payment arrangements, providers are cost centers: their revenue is fixed, so that providing services adds only to costs, not to payments. One explanation for the differing utilization patterns between fee-for-service and (capitated) managed care is that providers are converted from "revenue centers" to "cost centers."

In a *Health Affairs* article, Joseph Newhouse and colleagues have argued in favor of partial capitation. They raise concerns about stinting on needed care when a provider must bear 100 percent of the marginal cost of providing services. That concern may be strongest where providers' risk pools are too small to be stable or where providers are thinly capitalized.

Payment systems that combine attributes of fee-for-service and capitation create incentives to avoid unnecessary services but not stint on needed care. Many such approaches are possible.

I will describe four generic types of hybrid payment systems that combine some capitation with additional payments as services or costs increase. Those approaches are currently used in commercial markets, Medicaid, or Medicare demonstrations. They all limit the amount of risk assumed by a risk pool by paying extra for high-cost cases; that permits smaller risk pools to be more stable, lessening their volatility and susceptibility to big financial swings. To keep such systems budget neutral, the average capitation payments must be reduced by the amount being "carved out" for separate payment.

First-Dollar Partial Capitation. HCFA is experimenting with partial capitation payments in a demonstration project with an academic health center at the University of California at San Diego (UCSD). For impatient hospital services, HCFA pays the UCSD health plan half of the Medicare fee-for-service payment plus a capitaled amount. In part because of the reduced risk associated with this payment system, UCSD chose to offer a managed care plan that permitted direct access to the specialists on its medical school faculty.

Condition-Specific Carve-Outs. Pregnancy, acquired immunodeficiency syndrome (AIDS), solid organ transplants, and end-stage renal disease (ESRD) are all examples of disease or condition-specific carve-outs being employed by Medicaid agencies, HMOs, or Medicare. Some Medicaid agencies remove AIDS or other high-cost conditions from their capitation rates. Others exclude pregnancy-related costs from their normal capitaled payments. Instead, special payments are made for each case or each delivery.

Such payment systems can easily be adjusted to promote specific objectives. For example, if a goal was to promote prenatal care and limit caesarian deliveries, a flat "bundled" payment could be made for all hospital and physician services. In con-

trast, paying separate, higher rates for C-sections and lower rates for vaginal deliveries would instill fewer incentives to avoid C-sections.

For decades, Medicare has separated individuals with ESRD into a distinct risk pool. Now, Medicare is experimenting with paying for ESRD beneficiaries on a capitaled basis. Similarly, some HMOs carve out solid organ transplants from their capitation payments to providers, retaining the risk (and payment responsibility) at the plan level.

Individual (Specific) Stop-Loss Coverage. Many providers and health plans purchase private reinsurance to limit the costs of specific individuals or cases, which is often referred to as "specific stop-loss" coverage. Coverage thresholds, known as "attachment points," vary considerably. Some entities choose very high reinsurance thresholds, seeking to handle only catastrophically expensive cases. Others choose lower attachment points, seeking to reduce their financial exposure. The lower the attachment point, the higher the reinsurance premium—the amount carved out of the capitation rates—necessary to finance the costs.

Like the attachment points, the amount of excess costs reimbursed can also vary. In some cases, reinsurance pays 50 percent of costs in excess of the first threshold and 80 percent of costs above a second, higher threshold. Other policies pay I 00 percent of costs in excess of a threshold. By varying both the attachment point(s) and the share of costs paid, specific stop-loss policies can significantly moderate risk. At the extreme, certain stop-loss policies approach first-dollar partial capitation. (That occurs if the initial payment threshold is the first dollar.)

Aggregate Stop-Loss Coverage. Aggregate stop-loss coverage is also a commercially available product. Typically, that coverage presupposes the existence of an underlying specific stop-loss policy. If the cost of services for all members of the risk pool exceeded a specific level, the aggregate reinsurance policy could reimburse those excessive costs.

For example, assume that a physician has 300 capitaled Medicare beneficiaries in his or her risk pool and buys both specific and aggregate reinsurance. Any costs of physician services for an individual in excess of $7,500 would be paid by specific reinsurance. None of the amounts above the attachment point would be counted when calculating aggregate costs. However, all costs up to $7,500 would be included in calculating whether aggregate reinsurance payments would be triggered. In this example, two individuals might require extensive cardiac services and open-heart surgery, generating physician fees in excess of $10,000 each. The specific reinsurance policy would pay the costs over $7,500 in each case. Assume further that the average cost of physician services for each member of this physician's Medicare risk pool equals $1,800 (after excluding the catastrophic costs over the threshold) but that the physician only averaged a capitation payment of $1,440 per patient per year. Any costs averaging in excess of $1,728 per patient per year, which is 120 percent of the annual capitation payment, would qualify for aggregate reinsurance.

CONCLUSION

The success of Medicare+Choice is tied to how much, and how, Medicare pays. Low rates of increase in payments will tend to cause health plans to withdraw from or limit their presence in the Medicare+Choice market. Constrained payment rates will make benefit offerings less attractive to consumers, which will further slow growth in enrollment. Even though it is an improvement over the prior demographic adjuster, the PIP/DCG is a flawed mechanism for adjusting for risk selection. HCFA is working to develop an improved method for implementing stage two that would take account of service use in all settings. Because of the difficulty in markedly improving mechanisms that adjust payments, however, the Congress may wish to consider other approaches that would limit the risk borne by a pool.

Mr. BILIRAKIS. Now, if HCFA is made aware of—and they have been made aware of, because I know that we have been communicating back and forth—what the intent of the Congress is, and was at that time, and still is, are they prepared to adjust their thinking?

Mr. BERENSON. If there is a clear consensus in the Congress about that now, I think now deciding that it should be budget neutral, then HCFA can—we can technically do it in a budget-neutral way and would obviously follow the will of the Congress.

Again, I think there is some rewriting of history here about what the original intent was, and we followed what we thought the bill called for.

Mr. BILIRAKIS. So you are referring then to the piece of legislation that would clear that up; is that correct?

Mr. BERENSON. I think that's right. And, again, we are also very concerned about disruption to beneficiaries, about stability in the program, and that's why we carefully phased in risk adjustment over a 5-year period. In the first year, only 10 percent of the payment is based on the risk adjustor. Those assumptions about savings or reductions in payment to the plans assume stable case mix—that the plans won't respond to the incentives of risk adjustment by attracting sicker patients.

I'm not sure that assumption really should hold, either. When I drive to work, I hear ads all the time from hospitals about chest pain centers and an ability to take care of people who have acute, severe illnesses. With risk adjustment, one of the goals is for health plans to develop expertise in cancer management and heart management and to be able to change the case mix of their beneficiaries so that these kinds of impacts, in fact, won't happen.

We phased it in over 5 years so that the plans would have an opportunity to respond to the new program and be able to change their program.

So we, I think, share with the Congress the concern about disruption, the concern about plans pulling out because of risk adjustment, and feel that the phase-in schedule we've come up with is a response to that concern.

Mr. BILIRAKIS. Well, now, you were in the audience when Mr. Bryant made a comment about hoping that HCFA was not basically using its risk adjustor concept to squeeze out Medicare+Choice. You've heard that comment. How would you respond to that?

Mr. BERENSON. Again, we are approving right now—since the program, the Medicare+Choice program, has come in last July, officially, when we put out the regulations, we've approved 41 either new applicants or service area expansions. There are another 22 pending. We are very eager to promote the program. There is a private fee-for-service application in that we're reviewing. And we've tried to——

Mr. BILIRAKIS. So your answer is that you're not doing this because you want to squeeze out Medicare+Choice?

Mr. BERENSON. That's not our intent at all, and that's why we're phasing in risk adjustment.

Mr. BILIRAKIS. Let me ask you, then—and my time is almost up—you've estimated approximately $11 billion, I believe it is $11.2 billion, in savings as a result of the risk adjustment concept you've put into place. Where would that savings go? I mean, what's the intent there?

Mr. BERENSON. That savings goes back to taxpayers, basically, if——

Mr. BILIRAKIS. Where? Goes back to the Treasury?

Mr. BERENSON. Part A would go back to the trust fund, and I assume part B would go back to the Treasury.

But, again, I'm not sure that—I mean, that's an impact analysis assuming there is no change in the case mix and plans, and, again, I would wonder whether that is, in fact, going to happen. I mean, risk adjustment should produce the kinds of change such that that doesn't, in fact, occur.

Mr. BILIRAKIS. All right. Thank you.

Mr. Brown?

Mr. BROWN. Thank you, Mr. Chairman.

Dr. Berenson, thank you, again, for your patience and for joining us.

It seems self-evident that managed care plans enroll healthier-than-average seniors. I mean, anecdotally it seems like it is true. It seems like it is true when I go home and talk to people. And from a business standpoint it seems like it should be true that managed care companies want to attract the healthiest seniors, as insurance companies would want to do. It's good business practice.

Tell us about any evidence or studies that confirm the belief that most of us, I think, hold that there is some sort of cream skimming in the system like that.

Mr. BERENSON. Well, there have been a series of studies over the years. The most comprehensive was Mathematica's study, which looked at favorable selection and determined slightly more than 10 percent favorable selection. In other words, we were overpaying the plans by about 10 percent, or slightly more than that.

Now, that's getting somewhat dated. That was in the early 1990's. But there was a recent survey in 1996 of individuals, and it asked them about their ADLs, their disabilities, and found that beneficiaries in plans had lower levels of Activities of Daily Living (ADLs) than those who were in fee-for-service, and it was based on that information that PPRC made an estimate of overpayment to plans.

I think the risk adjustor, itself, is the most recent evidence. The risk adjustor determines whether favorable selection is taking place. Again, using the current model for risk adjustment suggests that there is favorable selection in plans such that they are getting about 7 percent more than they would be if they had average selection.

So there are a series of studies, and, again, it is not surprising. I've talked to medical directors of plans who basically say, "We do not want to have the reputation of being the best AIDS program around. We'd like to be second-or third-best. We don't want to attract people who have those kinds of high-cost illnesses."

And so it is natural, and so with risk adjustment they get rewarded for attracting those people, rather than the other way around.

Mr. BROWN. And so, in a sense, conversely, if the point of risk adjustment, which I think is to ensure that plans get more money for sicker seniors, then, conversely, plans get less money if they are particularly good at cream skimming, correct?

Mr. BERENSON. Whether it is intentional cream skimming or it is just that people who don't have multiple medical problems are more attracted to managed care, to HMOs, it could either be intentional or just how beneficiaries behave, but there should be an adjustment for that factor, and I think virtually everybody that is rec-

ommending a competitive health system identifies the need for risk adjustment to make the competition fair.

Mr. BROWN. Can we keep up in this institution? If the sophistication of the actuaries in an insurance company understand the sophisticated way of marketing and cream skimming, if you will, Congress responds by good risk adjustor language to really try to do managed care in the right way, pay more for sicker people, pay less for the least-expensive, healthiest, youngest, perhaps most affluent Medicare beneficiaries, can we keep up? Can we—because the next step after we pass good risk adjustor language is the sophistication of insurance companies will figure another way to sort of keep ahead and ensure good business practice, assure and ensure the least-expensive people.

Is this sort of a treadmill that we're on that we can't quite keep up with their pursuit of profits this way in for-profit medicine?

Mr. BERENSON. Well, risk adjustment can't be the only answer. I mean, most people agree that risk adjustment will never be able to fully predict somebody's risk, and that's not our goal. There will still need to be other routine oversight that we do of marketing materials that we do right now so that plans don't really overtly abuse their trust, essentially, to just market to healthy people.

I mean, the example that has been used for many years is to offer an enrollment sign-up place on the third floor of a walk-up, and so anybody who can make it up there gets to sign up. That doesn't essentially happen, but we have a responsibility——

Mr. BROWN. It's not illegal, is it?

Mr. BERENSON. [continuing] to oversee the program so that that kind of thing doesn't happen.

Risk adjustment is one tool, but we have an obligation to also assure that other practices don't go on.

Mr. BROWN. And you do that well?

Mr. BERENSON. We take it seriously and are improving our capabilities in that area.

Mr. BROWN. Do you do it well?

Mr. BERENSON. We do it well.

Mr. BROWN. Okay.

Mr. BILIRAKIS. Mr. Ganske?

Mr. GANSKE. Thank you, Mr. Chairman.

Dr. Berenson, I want to read to you from the summary from this 2-month-old GAO report. "Medicare+Choice reforms have reduced but not likely eliminated excess plan payments," and then elicit your response.

It says, "Health plans have not, however, produced the expected savings for the Medicare program. Until 1997, Medicare plans were paid 95 percent of the expected fee-for-service cost for beneficiaries. The 5 percent discount was established to allow the program to benefit from the efficiencies commonly associated with managed care. However, numerous studies conducted by us, the PPRC, which has been incorporated into the Medicare Payment Advisory Commission, HCFA, and others demonstrated that Medicare programs spent more on beneficiaries enrolled in health plans than it would have if the same individuals had been in fee-for-service.

"This unexpected result occurred because Medicare payments were based on the estimated cost of fee-for-service beneficiaries in

average health and were not adequately adjusted to reflect the fact that plans tended to enroll beneficiaries with better-than-average health who had lower health care costs, a phenomenon known as 'favorable selection.' "

And this is the paragraph that I think is important and the subject of today's hearing: "PBA's new formula for paying health plans implemented in 1998 takes steps to lower but probably does not eliminate excess plan payments.

"Among other changes, the new formula slows the growth of plan payment rates relative to fee-for-service spending growth for 5 years. More importantly, BBA mandates the implementation of health-based risk adjustment system intended to better match payments to beneficiaries' expected health care costs and reduce the excess payments caused by favorable selection."

This is important right here. "The effect of these changes is reduced, however, because BBA locked into place the excessive payment rates that existed in 1997. For example, when HCFA actuaries set 1997 payment rates, they based those rates on a forecast of 1997 fee-for-service spending. The actuaries now know that those rates were too high, because the forecast overestimated fee-for-service spending by 4.2 percent. However, BBA specified that 1997 rates be used as the basis for 1998 rates.

"This implicit inclusion of the forecast error resulted in excess payments of $1.3 billion in 1998. Furthermore, the annual excess payments associated with the forecast error will increase each year as more beneficiaries join health plans."

Would you comment on this summary? Do you think that this is an accurate summary?

Mr. BERENSON. Yes, we think that is an accurate summary, and I've spent a lot of time working to understand the AAHP's argument about a "Fairness Gap" that we are under-paying the plans.

They've identified a number of areas where they think they are being underpaid, and a significant piece of it is risk adjustment. They've ignored in their analysis, really, that 4.2 percent.

When we do all the overpayments and the underpayments—and I could go through it if you're interested—we actually come out at about 96 percent, is what we're paying the plans, in fact, 1 percentage point more than the 95 percent, which we sort of understand, going back 20 years. That is, in fact, the basis for the President's proposal on how the structured pricing, competitive pricing, is determined.

So we, in fact, did overpay the plans in 1997 and don't have an opportunity to recoup that because the BBA did not permit that, and it is one of the items that goes into the overpayment category and where ultimately we're paying the plans about where we think we should be paying the plans, in aggregate.

That doesn't mean that there might not be a plan in a certain geographic area, like Tennessee, that might be getting underpaid, but in aggregate we think we're pretty much where we are supposed to be.

Mr. GANSKE. I appreciate that.

Mr. BILIRAKIS. The gentleman's time has expired.

Ms. Eshoo?

Ms. ESHOO. Thank you, Mr. Chairman.

Thank you, Dr. Berenson, for your testimony to the committee.

My question is about adequate payment. Adequate payment, obviously, can mean different things to different people. When Medicare+Choice plans say "adequate payment," it seems that they mean compensation large enough to cover not only the Medicare benefits package, but also supplemental benefits such as prescription drugs and zero co-pays.

Is that an accurate perception of adequate payment? If it's not, I'd really like you to correct it, but if you think it is——

Mr. BERENSON. I think that is one of the confusions in the discussion that people have about adequate payment.

The statute requires we make a payment to the plans based on this complicated formula, and if the plans are able to provide the services, the mandated Medicare Part A and Part B services, for less than that payment, they're able to provide additional—they're required to provide additional benefits, essentially, and that tends to be prescription drugs, it tends to be at a zero premium in many, many markets. It can be preventive medicine services, it can be hearing aids. It can be a series of additional benefits.

And we've calculated that overall, again, on a national basis, that as much—well, about $54 per member per month, or about 10 percent or so, of the payments that the plans receive are in this additional benefit category. They are actually able to provide the Medicare benefits and have 10 percent more to provide additional benefits. That's what some beneficiaries are taking advantage of.

What we've observed with some of the pull-outs is that the plans that pulled out, in fact, were offering additional benefits along these lines and, for whatever reason, decided that they could not cut back on those benefits and still attract beneficiaries, or maybe there were other factors going on.

So when we talk about paying adequately, I think we are quite confident that we pay adequately to provide the Medicare benefit package. We've been paying more than that in many geographic areas so that plans can provide additional benefits, and what is happening is the plans really are not able—we're finding plans are not able to attract beneficiaries with other than very generous additional benefits. They're not going there because the quality is better or because there is more emphasis on coordination and prevention. It really is relying on their ability to provide these additional benefits.

Ms. ESHOO. Does HCFA have the ability to do any essentially exit interviews?

Mr. BERENSON. That actually came up very recently in a discussion we had with MedPac. We're looking into that and trying to see if it does require OMB sign off, whether it is a formal survey or not, but we and MedPac, I think, have determined that we would like to understand the plans' perception of why they are pulling out. We would like to know the reasons, in a more structured way than we have now, which is more anecdotal. We'd like to do that.

Ms. ESHOO. Thank you. I think that that could prove to be instructive, if you can get rid of some of the weeds around the administrative or how you actually implement that.

If you were to make a check list relative to Medicare+Choice and the pluses and the minuses, on the plus side and the minus side

what would you list? Does one outweigh the other? Is this a worthy experiment?

In some ways I think that we are being held hostage by the groups coming in and saying—and I don't know where the legitimacy of this lies. It is always easy to say that a federally funded program is not paying enough to make it work, and so, you know, we hear from our constituents. They come flying to us and saying, "This is an outrage that my insurance carrier is pulling out of the market. Do something about it."

Is there a legitimacy to that? Is this working well? Did we fund this fairly and adequately?

Of course, that's pitched up against the large picture that I mentioned—the much larger picture that we are struggling with this in the, you know, waning hours.

Mr. BERENSON. I'm not going to sort of give you a total answer, sort of on the spur of the moment. Two things immediately come to mind.

One, it is more than an experiment—17 percent of beneficiaries are now getting their care——

Ms. ESHOO. How many have dropped out, out of that 17 percent? How many have pulled out of the market?

Mr. BERENSON. How many beneficiaries have lost the plan?

Ms. ESHOO. Yes.

Mr. BERENSON. Well, last year it was about 400,000 and this year a little over 300,000, so that's 700,000. It's about 10 percent, or a little more than that, have been affected, although, again, as the graph showed, more are in now than were in, even with the pull-outs.

Ms. ESHOO. Yes.

Mr. BERENSON. So one is a serious program. Many beneficiaries like the option of being in an HMO, and that should be provided to them, and we hope that we'll have other options like that.

On the other hand, what we've also learned from the pullouts is that a beneficiary cannot be assured that their prescription drug benefit or other additional benefits, but particularly prescription drugs, will be there. It sort of depends on the vagaries of the market.

There's about a third of the beneficiaries who do not have access to a plan that offers prescription drugs in the first place, and we've seen a number who are not able to stay in a plan because the plan has pulled out, they're not able to have easy access into a Medigap plan that offers prescription drugs, so I think that points out, although it is an important, necessary program, Medicare+Choice, I think having a prescription drug benefit in the basic Medicare benefit package will produce some equity in the program and not have it be based on where somebody lives.

Ms. ESHOO. Yes. Thank you.

Mr. BILIRAKIS. The gentlelady's time has expired.

Ms. ESHOO. Thank you.

Mr. BILIRAKIS. Mr. Bryant?

Mr. BRYANT. Thank you, Mr. Chairman.

Thank you, Dr. Berenson, for your testimony today.

Just to follow very quickly the comment from the gentlelady from California about are we adequately funding health care, not only

in this area of the Medicare+Choice but in the fee-for-service, I know providers in my District are complaining across the board that we're not paying enough.

Let me also say that, as you've mentioned, the vast majority of Medicare+Choice enrollees, I think you've said that they aren't affected, but you just indicated that some 700,000 enrollees over the last 2 years of the 6 million people in the program have had their coverage disrupted. Certainly, that is a significant problem in my view, together with the fact that we've had 99 plan withdrawals this year, which is, again, the same number from last year total, two together of 99 years in a row [sic] that we've had withdrawals.

Dr. Berenson, I would like, if you would, to late file with your testimony some answers to some questions.

Very quickly, you've mentioned the 41 new plans you've approved. I need to know, are these expansions in markets that already have plans? And how many of these are in counties that previously had no choice plans? And how many are plans that are new to Medicare+Choice? And how many cover areas where there—well, scratch that question there.

[The following information was received for the record:]

The 42 plan approvals since July 1998 are providing service in a total of 171 counties, including 46 counties that previously had no Medicare+Choice plan and 125 counties that already had a Medicare+Choice plan. Of the 42 approvals, 22 are new Medicare+Choice contractors and 20 are current Medicare+Choice contractors that have expanded their service areas.

One other question that, again, I'll ask you to late file your answer on, is that on page 6 of your statement you note that you've listed the—you've made a few changes in the program's regulatory framework, and I need to know, in your answers, how many of the more than 800 pages of regulations did you retract, and did you scale back from any of your 42 operational policy letters?

[The following information was received for the record:]

The June 26, 1998, Medicare+Choice (M+C) interim final rule implementing the program consists of 148 pages, 51 pages of regulation text and 97 pages of "preamble" text explaining the legal and policy justifications for the regulation.

The February 17, 1999, "mini-rule" made important refinements to the original regulation that increased protections for beneficiaries while minimizing the administrative workload for plans. For example, the new rule:

- clarifies that beneficiaries enrolled in a M+C plan that withdraws or is terminated from Medicare are entitled to enroll in other remaining, locally available M+C plans;
- specifies that any changes in plan rules must be made by October 15 to ensure beneficiaries have all the information they need to make an informed choice during the November annual open enrollment period;
- waives the requirement for an initial health assessment within 90 days of enrollment for commecial health plan enrollees who remain in the same managed care organization's Medicare+Choice plan when they become eligible for Medicare at age 65, and for enrollees who switch plans but remain under the care of the same primary care provider;
- allows plans to choose the form of the initial health assessment;
- stipulates that the coordination of care function can be performed by a range of qualified health care professionals, and is not limited to primary care providers;
- limits the applicability of provider participation requirements to physicians rather than all health care professionals; and,
- aligns requirements for terminating specialists with the process for other providers.

These refinements were based on public comments regarding the interim final rule. We are committed to continuing open dialogue with all interested parties on how to strengthen, streamline, and improve the Medicare+Choice program. We in-

tend to publish a comprehensive final rule with further refinements this fall. However, we have not and are not retracting regulations.

We have, in fact, now issued 100 operational policy letters, frequently in response to requests for guidance from managed care plans and industry associations. These letters are an effective and efficient way to make further refinements and communicate clear policy guidance to a wide variety of M+C stakeholders in a timely manner.

Mr. BRYANT. Now, Doctor, let me ask you, for your testimony today, do physicians in the fee-for-service have to do the same amount of quality reporting as they do in Medicare+Choice? And what would be your answer there?

Mr. BERENSON. We're very actively working with the PRO program. The focus initially is on hospitals, and we will be doing quality improvement projects very similar to what we're asking the health plans to do, and the physicians who are on staff at the hospitals will be involved with that.

We've also made a commitment, because beneficiary choice between plans and fee-for-service is so important, to put up the same quality measures, the HEDIS indicators, that we have from plans. We want to put up equivalent information about the fee-for-service sector, as well.

In a couple of areas, plans do better than fee-for-service, and we want the beneficiaries to see that to help them make their decisions.

So we are trying very hard to apply an equal yardstick here, to have the same requirements on fee-for-service and Medicare+Choice because there are quality problems in fee-for-service.

Mr. BRYANT. So as of now, though, the choice providers have to report the quality reports more than the fee-for-service have to at this point? You're trying to——

Mr. BERENSON. That's right. I would say yes. In our regulations and the so-called "QISMC" requirements, we do have specific reporting requirements for plans. Yes.

Mr. BRYANT. Okay. On page 8 of your statement, you indicate that you assume that people taking prescription drugs on average are less healthy than others.

Ms. Moon, in her testimony—who will be on the second panel—suggests this perhaps. And I would ask you that, if people are joining the Medicare+Choice plans for the prescription drug coverage, perhaps they actually are sicker than you think. Would that be——

Mr. BERENSON. Well, I've actually seen some writing. I saw a "Consumer Reports" analysis that said that plans were providing prescription drugs to get favorable selection. That made no sense to me, because people with prescription drug needs actually may be sicker.

What is happening, at the same time, is that a number of the plans are reducing their drug caps down to a very low level, so that the sickest of the Medicare beneficiaries would not get a lot of benefit.

But I agree with the thrust of your question, that, in fact, prescription drugs do not favorably select.

Mr. BRYANT. Thank you.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. Deutsch?

Mr. DEUTSCH. Thank you, Mr. Chairman.

I have a couple of questions specifically related to south Florida, if you can answer them. I mean, they're general enough that hopefully you can.

In Dade and Broward Counties, increases for Medicare+Choice payments have been held to 2 percent per year for the last 2 years. Does this increase bear any relationship to the cost of providing health care in south Florida?

Mr. BERENSON. I am quite confident that the plans in Dade County—which is one of the highest payment counties in the country—are able to provide the Medicare benefits for substantially less than the payment.

The GAO, in one of their very recent reports, looked at Los Angeles County, which is similar in many ways to Dade County, and found that the plans in L.A. County were providing the statutory benefits at 79 percent of the payments. I don't have a specific number for Dade County.

But I also would point out that, of the new plans that we are reviewing and are pending, we have already approved two new plans in Dade and Broward County, and there are two more who have applied to go into Dade and Broward County, so, to the extent that they view the reimbursement levels as a problem, I don't think they'd be going in.

At some point, 2 percent year after year would start to become a problem, but at this point, you know, the competition is very active in Dade County and the beneficiaries are getting substantial additional benefits.

Mr. DEUTSCH. All right. Let me just mention this Dade and Broward. I mean, there's many beneficiaries in Broward, maybe even more than Dade, as well.

I guess one of the things related to your sort of answer, the overall increases of health care—which I guess are over or about 5 percent at this point, so, in terms of what the plans are paying for the services that they're getting, you would assume that those services are close to that average cost of 5 percent, so their reimbursement is going up at 2 percent. By definition, are we then saying that the benefits that they are going to be able to provide are going to be decreased? Is that the policy decision that effectively we're making?

Mr. BERENSON. Well, obviously, the plans have a lot to say about it. If they are able to provide the services at less than 5 percent, they'd be able to be in a better situation.

On the discussion of whether fee-for-service payments and our payments should somehow bear a relationship to each other, I would simply point out that it is often in areas where fee-for-service Medicare is at the highest, which have over-capacity or other reasons, where plans do pretty well. They are able to negotiate better contracts, get better discounts, be able to do very useful utilization management precisely in the areas where Medicare fee-for-service costs are high. So I would hope that there are some things that are new. Prescription drug costs are going up and the plans haven't really gotten a hold of those costs, but the whole goal of providing the 5 percent discount off of fee-for-service to the plans and the hope for managed care is that they would be able to provide services at a lower cost than fee-for-service.

Now, obviously, if they can't and they're only getting 2 percent, at some point those lines cross and the plans can't provide the additional benefits.

Mr. DEUTSCH. I just want to follow up on a couple of things you've mentioned regarding prescription drugs.

Obviously, traditional Medicare doesn't provide prescription drugs, so you mentioned the figure of two-thirds of the plans providing some type of prescription drug coverage for Medicare HMO beneficiaries. I mean, would you view it as a good thing if they didn't provide it?

Mr. BERENSON. In the plan, we put a basic prescription drug benefit into the basic benefit package that the plans—we pass through the subsidy to the plans, and they are able to provide prescription drugs——

Mr. DEUTSCH. Right, but let's—you and I are both optimistic that something like that is going to pass. Let's say it doesn't pass. We're still in the world we are today, where normal fee-for-service Medicare doesn't provide prescriptions.

I guess I'm just trying to get a sense from the policy perspective what you are articulating. It talks of 79 percent, 85 percent, whatever percent, 90 percent of providing the traditional coverage that Medicare covered, and for that additional money that they have, hopefully in some markets they are competing with each other for clients.

I mean, I'm trying to get a sense from you. Is it a good thing that they're cutting back on benefits? Are you looking to basically manipulate the reimbursement level, where it is closer to what it should be costing them to provide traditional, or isn't that the whole point of an incentive—to get them in the plan, so that theoretically it does save Medicare money, as well, it saves the Federal Government and provides additional service at the same time?

Mr. BERENSON. I get your point.

Mr. BILIRAKIS. Be brief with your response please.

Mr. BERENSON. Basically, the plans are providing prescription drugs. They are not cutting back their commitment to providing prescription drugs. They are reducing some of the caps, changing formularies, doing some things to make it manageable. That's in response to cost pressures.

It is better that they are staying in the program providing somewhat reduced benefits than the plans that are pulling out and really giving beneficiaries no choice.

Mr. BILIRAKIS. Mr. Burr to inquire.

Mr. BURR. Thank you, Mr. Chairman.

Welcome, Doctor. Let me ask you, why did 700,000 people over the last 2 years drop out of Medicare+Choice?

Mr. BERENSON. Well, it's the plans that dropped out, leaving 700,000 beneficiaries without their plan, so it is—the plans actually—the beneficiaries, over half of them, went back into a plan where they had an option to, so——

Mr. BURR. Let me read you the testimony in the Senate from the director of CBO in June. He said, "Having well-established plans vote with their feet and withdraw from their key Medicare+Choice markets is an indication that payment and other conditions of participating in Medicare+Choice may be too stringent."

Do you agree or disagree with that?

Mr. BERENSON. They are obviously making business decisions, and in some cases they related——

Mr. BURR. Do you believe what the CBO's conclusion was, that the reimbursements or the policies are too stringent?

Mr. BERENSON. No. I mean, I think the aggregate payment level for the M+C plans is adequate. There are some geographic areas where probably it is not adequate, and I don't believe that the regulatory structure is overly burdensome.

Mr. BURR. Is the fact that, even with these hurdles in the way, that seniors are striving to go to Medicare+Choice, what does that say about traditional Medicare? Does it meet their needs?

Mr. BERENSON. Many beneficiaries see a positive value in Medicare+Choice because of the additional benefits, and that's why we want to modernize the benefit package for traditional Medicare.

Mr. BURR. Would HCFA like to see 100 percent of the beneficiaries in the Medicare+Choice plan?

Mr. BERENSON. I think we want to create a level playing field so beneficiaries can pick the approach that is most appropriate for them. Some like managed care a lot. Others feel much more comfortable with the freedom of choice in traditional Medicare, and we want to make it possible for them to have that choice.

Mr. BURR. What is that choice in traditional Medicare?

Mr. BERENSON. The choice in traditional Medicare is to be able to go to essentially any doctor or any hospital without some of what managed care brings with it, whether you like it or—there's more coordination, there's more direction, there's more selection of providers in managed care. In traditional Medicare we have a much broader——

Mr. BURR. But less in the way of coverage?

Mr. BERENSON. Less in the way of coverage.

Mr. BURR. Less in the way of coverage.

Let me ask you about your comment about structured, competitive pricing. Can you tell me what that is? What is structured competitive pricing?

Mr. BERENSON. I don't remember the specific reference, but I think I was referring to the President's plan.

Mr. BURR. You were talking about the President's plan. Yes.

Mr. BERENSON. Basically, under the President's plan, the plans—instead of having the system that we have right now, which is based on a complex formula that results in payment levels in Tennessee that I think make it very difficult for a plan to stay in, we would have the plans determine, in relationship to the fee-for-service payments that Medicare makes, what the plan's price is, and the plan gets that price. The plans get it either from the government or from the beneficiary.

To the extent that they are able to provide those services at a lower cost, they are able to give rebates to beneficiaries and attract those beneficiaries who then are in a position to either keep the savings or to purchase additional benefits.

Mr. BURR. Are you familiar with the Progress Policy Institute?

Mr. BERENSON. Progressive Policy Institute?

Mr. BURR. Progressive Policy Institute. Let me read you their quote on the President's plan. "The President's proposal of Medi-

care spending would continue to be determined by the cost of traditional fee-for-service plan, which is determined by the prices Congress sets for payments to providers."

Is that accurate?

Mr. BERENSON. That's part of how the traditional fee-for-service total payments are——

Mr. BURR. We determine what price we're going to reimburse, and, consequently, you use that as a gauge to determine what the reimbursement of Medicare+Choice is, right?

Mr. BERENSON. No. Under the new proposal, the plans would determine, and if, in fact, we're paying too much or paying inappropriately, they would be in a position to charge a lower price to the beneficiary.

Mr. BURR. Let me ask you about the benefits in the President's proposal, since you brought it up.

If a beneficiary in the first year had $2,000 worth of annual drug costs, anything over the $2,000, who would be responsible to pick that up?

Mr. BERENSON. The beneficiary would.

Mr. BURR. There's no stop-loss for the beneficiary?

Mr. BERENSON. There is no stop loss. What the beneficiary benefits from is the discounts that the PBM is able to——

Mr. BURR. Is there any other health insurance policy out there today where you would pay for an annual premium where, when you got to a certain amount, you, as the beneficiary, were responsible for 100 percent of it?

Mr. BILIRAKIS. A brief response please, Mr. Berenson.

Mr. BERENSON. I honestly don't know.

Mr. BURR. Let me just read in closing, Mr. Chairman, just one statement again from the Progressive Policy Institute.

"The President's proposal advances the debate, but it also could be improved in several areas. It would inject strong competitive forces in Medicare, but it fails to capture the potential savings on behalf of taxpayers. It adds a drug benefit, but in a way that is poorly targeted to help those most in need. It contains some helpful limits on Medicare spending, but its cost containment is not sufficient to cover the cost of new drug benefits, let alone reduce Medicare spending for the long run. It would prolong the solvency of Medicare, but only through accounting gimmicks which could actually delay more-aggressive action to restrain long-run cost."

I yield back.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Green to inquire.

Mr. GREEN. Thank you, Mr. Chairman.

Let me follow up with that. The President's plan on prescription medicine, granted, may not go as far, but I also don't agree always with what that institute says.

Dr. Berenson, let me revisit a little bit what Dr. Ganske was talking about with the difference in data that AAHP is talking about.

You said that HCFA estimates that plans are getting paid 96 percent of the fee-for-service rates, not the 82 percent that the Association or the HMOs are saying?

Mr. BERENSON. Yes.

Mr. GREEN. Okay. And this is because of a mistake in the Balanced Budget Act base rate for payment plans which are resulting in overpayments to the plans?

Mr. BERENSON. Well, that represents 4.2 percent of an overpayment. I think a fundamental disagreement we have with AAHP—and they'll be up next—is that we think risk adjustment is a fair adjustment and they use that as a deduction from their fee-for-service equivalent payment. We think it is an appropriate modification because of healthier selection. So we have a disagreement there.

We do view a 4.2 percent overpayment that I don't think has been in their calculations.

We agree that the BBA did reduce 2.8 percent of—each year there is a reduction. And I think we have a disagreement over the GME carve-out as to whether that should be viewed as a reduction to the plans or not. We actually make those payments to the teaching hospitals.

So we do have some disagreements on interpretation of the data.

Mr. GREEN. In the Balanced Budget Act, wasn't the HMO payment deleted from or de-linked from the fee-for-service rate?

Mr. BERENSON. That was, I thought, one of the goals.

Again, I would point out that the withdrawals that are occurring this year are tending to take place in lower payment areas, not the higher payment areas that is part of the analysis, and again there is, in my view, not a connection between what we would pay fee-for-service and what we would pay plans, because plans are often in the best position to save costs in high-payment areas and in a relatively weak position, say, in some rural areas where there are few doctors and one hospital. They're not in as good a position to get discounts.

So the link to fee-for-service is one that I think the BBA tried to limit and de-linking makes some sense.

Now, in the President's plan, however, we want to preserve what the blend in the floor county payment increases have to the low payment areas and recognize that the plans need to compete in a geographic area.

So we, in fact, provide an opportunity for plans to compete with an equivalent fee-for-service payment level.

Mr. GREEN. It seems like, again, under the BBA—and I know there were lots of questions that I have in things that were done in 1997 that maybe we wouldn't do today because of our economy, but HMOs are supposed to save Medicare money by managing care better, so it seems like wouldn't it be logical that the payments be less than the average fee-for-service beneficiary in a geographic area?

Mr. BERENSON. There still is a 5 percent reduction which is supposed to be for managed care efficiencies.

You know, I partly don't know how to react to some of the plans I've met with who say, "Our costs are going up 6 or 8 percent," as if that means we should pass through that 6 or 8 percent because their costs are going up 6 or 8 percent.

The promise of managed care is that they can actually hold costs down, and so I don't think we should be in a position where we are simply passing through the cost increases.

I think it is difficult at this point for plans. They're raising premiums in the commercial side 10 percent or so. They are withdrawing from FEHBP. This is not a Medicare only problem, at all. Plans are having difficulties at this point managing costs, and I think that should be generally recognized.

Mr. GREEN. Lots of other reasons go into it other than reimbursement. For example, maybe you didn't sign up enough enrollees to really make an HMO possible, whether it be a rural area predominantly or even an urban, and we see a lot of volatility in the market where plans are merging with other plans and everything else.

Mr. Chairman, let me just follow up on the question that one of our colleagues asked about the quality control requirements for HMOs——

Mr. BILIRAKIS. Make it brief, please.

Mr. GREEN. [continuing] and not fee-for-service, and if Dr. Berenson can talk about it.

Over the next few years Balanced Budget Act, seniors, and HMOs will no longer have the freedom to go back to fee-for-service, so there is quality control on HMOs and not fee-for-service, simply because fee-for-service you can always go down the street to another doctor or different hospital or something like that, whereas with HMOs shortly there will not be that ability for seniors to shop around. Is that correct?

Mr. BERENSON. That is correct, and I think there is concern about a plan that is capitated that has to work within a capitated budget about whether they are, in fact, taking shortcuts.

Having said that, we do want to provide beneficiaries information about fee-for-service. They should know how hospitals compare to each other with some objective data. Ideally we'd even get that information about physicians.

So we are committed to doing that. We would agree with your point about it being especially important for locked-in beneficiaries before they make that kind of a decision, they really should have some quality information.

Mr. GREEN. Thank you.

Thank you, Mr. Chairman, for understanding.

Mr. BILIRAKIS. Mr. Barrett to inquire.

Mr. BARRETT. Thank you, Mr. Chairman.

Dr. Berenson, you said in your testimony that there is considerable evidence that we have overpaid and continue to overpay plans.

The GAO study or your analysis, is that across the board, or are there different degrees of error in different parts of the country?

Mr. BERENSON. Well, the BBA attempted to sort of decrease the disparity. I guess it was Dr. Ganske who pointed out that in Iowa we pay much less than we pay——

Mr. BARRETT. I understand. My question——

Mr. BERENSON. [continuing] in Florida.

Mr. BARRETT. My question is, Has the GAO or has your analysis shown that that overpayment is different in different areas?

Mr. BERENSON. The GAO focused in on L.A. County and emphasized a high payment area and actually quantified what the difference was. I think it is clear that the areas that are limited to a 2 percent increase at this point probably are in a better financial situation than the low-payment areas.

Unfortunately, however, many of the pullouts this year were in areas where the plans got 8 or 10 or 12 percent increases, which was the intent of the blend in the BBA, and we have to assume that the pull-outs were for other reasons because the payment levels were beginning to get to a reasonable level.

Mr. BARRETT. So evidence has shown this year that the withdrawals are occurring more often in what have historically been the low-payment areas?

Mr. BERENSON. That's right. Essentially, the plans who have a—in fact, I have some data here. For plans who have a per capita payment between $450 and $500, which is a low-end payment level, 12 percent of the enrollees lost their plan. For plans that had greater than $600 of payment as a result of the formula, only 1.3 percent of enrollees lost their plan.

So it was clear that the withdrawals tended to occur in low-payment areas, which is what one would probably expect.

Mr. BARRETT. So when I see the headline that says that the GAO report says that these plans are still over-paid, I should infer that they are talking about in higher reimbursement areas?

Mr. BERENSON. I think in aggregate.

Mr. BARRETT. I live in a District that says they are under-paid, so when I come to my HMOs and say, "Don't worry. In the aggregate you are overpaid," they say, "Well, the aggregate——"

Mr. BERENSON. I understand.

Mr. BARRETT. "Don't talk to me about that." So I'm still not getting what I consider to be an adequate answer.

If we have a problem in lower-paid areas where HMOs continue to drop out, we have a two-tired health care system in Medicare+Choice, don't we?

Mr. BERENSON. Yes, and that's why, again, I think we need a reform there, and why a competitive model—competitive pricing—would be better than thinking you can get a national formula to work well in every county or in every district, which I think is a real problem.

Under the President's proposal, the plans will determine what their costs are, and that's what they're going to get paid. They're not going to get paid based on an arbitrary formula. As well-intentioned as the formula is, and it has accomplished a number of things by bringing up the low-payment areas, it can't get it right in every area.

Mr. BARRETT. I don't represent North Dakota, but let's talk about North Dakota for a second. My understanding is that there is really little HMO penetration there. How is it going to work in North Dakota?

Mr. BERENSON. Well, first, in North Dakota, the basic problem—we've raised the floor for—I assume the counties in North Dakota are now protected by the new floor payment. The difficulty of getting managed care into a very rural area relates to factors other than the absolute payment rate. The plans have to get a network, and often they have to contract with what may be a sole community hospital with a limited number of physicians or nurse practitioners, and they really don't have the negotiating ability or relationships with those providers to accomplish that network.

I think there are factors like that which are really more related to the ability of HMOs to get into rural areas than to the payment levels.

Mr. BARRETT. Let's talk about the demonstration projects. How are the demonstration projects going?

Mr. BERENSON. Well, we have an important—the BBA set up an important competitive pricing demonstration. The Competitive Pricing Advisory Committee selected two sites. We've worked with the local advisory committee and have extended the start date to January 1 of 2001.

The problem now is that there is at least some Congressional interest in exempting Kansas City and Phoenix as demonstration sites, and, if that happened, I think it would be very hard for us to proceed with the demonstration.

This is exactly the kind of demonstration we need to have to know how an alternative to the current administered pricing model would work, and we really think it needs to go forward.

Mr. BARRETT. And why is there opposition to that?

Mr. BERENSON. Well, everybody is for competition until it is in their own backyard, that is what I assume.

The Competitive Pricing Committee spent a lot of time and carefully selected those sites. Many of the members of the advisory committee think these demonstrations should go forward, but obviously some think it is better if the demonstrations are somewhere else.

I think that's an issue here.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. BILIRAKIS. All right. I think that probably takes care of the inquiries.

Dr. Berenson, as per usual, we would ask you if you would be amenable to getting written questions and responding in a timely fashion.

We are very grateful you have taken time to be here. Thank you, again, for your patience.

Mr. BERENSON. My pleasure. Thank you.

Mr. BILIRAKIS. The second panel will please come forward: Ms. Karen Ignagni, president and chief executive officer of the American Association of Health Plans; Mr. John Powell, vice president of government relations for the Seniors Coalition; Ms. Esther Canja, president-elect of the American Association of Retired Persons; Dr. Marilyn Moon, senior fellow with The Urban Institute; and Rabbi Morton Malavsky from Hollywood, Florida.

Welcome, ladies and gentlemen. As you may know, your written testimony is made a part of the record, and we will turn the clock to 5 minutes for your vocal testimony, which I would hope would complement or supplement your written testimony.

Ms. Ignagni, we'll start with you.

STATEMENTS OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF HEALTH PLANS; JOHN POWELL, VICE PRESIDENT OF GOVERNMENT RELATIONS, THE SENIORS COALITION; ESTHER CANJA, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS; MARILYN MOON, SENIOR FELLOW, THE URBAN INSTITUTE; AND RABBI MORTON MALAVSKY

Ms. IGNAGNI. Thank you, Mr. Chairman, members of the subcommittee, we're delighted to have this opportunity to testify this morning.

I'd ask that my full statement be submitted to the record.

Mr. BILIRAKIS. It is a part of the record.

Ms. IGNAGNI. Thank you very much, sir.

I'd like to make six points this morning. I know that you are being asked to evaluate this issue at a time when we are having a very heated debate surrounding managed care, and, wherever you stand on this political question, we hope that you will keep an open mind on Medicare and how much, in particular, beneficiaries stand to lose if they lose their choice.

We are in crisis in this program and we are at a crossroads. What you do this year will determine whether the Medicare beneficiaries continue to have the choice of purchasing affordable comprehensive alternatives to traditional Medicare. Behind all the numbers and all the rhetoric, that's what is at risk.

Our beneficiaries are getting older. They don't go back to fee-for-service. We have a very high proportion of poor and near-poor individuals. For them, if you end Medicare+Choice it means unaffordable Medicare.

There has been a great deal of discussion about the impact of the 400,000 individuals affected by withdrawals last October 1, in addition to the 327,000 that will be affected beginning next year.

I don't want to add to that discussion, since it has been very well treated thus far, but I do hope that you will understand and really will give emphasis to the fact that we are at a net reduction.

The idea that everything is fine and that we don't have to act this year couldn't be further from the truth. The new approvals are generally in existing areas or in service area expansions. Fewer beneficiaries now have more than a choice of one plan versus where we were simply last year, and we've endeavored through our numbers—and I know there has been a great deal of discussion about that this morning—to provide a comprehensive picture of what is occurring and why.

Mr. Brown, you made the point early in your opening statement that you would like more briefing, and we would be delighted to do that. My staff briefed the minority and the majority staff of this committee prior to Memorial Day. We have had three briefings with HCFA, numerous phone calls back and forth with HCFA. We've briefed CBO. We've briefed the White House. We've briefed Medpac on numerous occasions and we'd be happy to come back.

You've had quite a great deal of discussion about this infamous 4 percent. We have, in the numbers before you, included the 4 percent, so all of the estimates that we are talking about in our numbers include the 4 percent.

My staff was at HCFA last week having a discussion with all of their technical folks looking over the numbers, trying to understand what the real impact was across the country. We were asked this question. We were very, very clear that the numbers before you include the 4 percent.

Now, we don't agree with the 4 percent assumption, but I remember very clearly several months ago sitting before the administrator and telling her that we understood this was going to be a great matter of controversy. We wanted our numbers to be helpful, to be useful, and we didn't want that to be a distraction. So we would be pleased to work with anyone on this committee to get their hands around what the impact is in this endeavor in this area.

And I'd also like to go to the matter that has been the subject of much discussion about whether or not plans are making routine business decisions here or whether we really are in crisis.

Remember that payment and regulatory decisions dictate the environment that health plans operate in, and any efforts to suggest that these are not responsible for the current crisis is really aimed at diverting attention from it.

There has been a suggestion that there is a 5 percent growth factor. I think one could construe that remark as if to say that most plans in most areas would receive a 5 percent growth, and we know what is going on in the area of inflation.

In fact, 78 percent of Medicare+Choice beneficiaries live in areas where the rate of increase would be under 4 percent. A full 38 percent live in areas—many of yours on this committee—where the increase would be under 2 percent.

So with fee-for-service rising an average rate of 5.8 percent, when you look at the compounding effects of two and two, and anywhere between two and four, and where you see most of the beneficiaries are living, you can see why we have termed this a "fairness gap." We are urging you to pass the legislation before you, H.R. 2419. While it will not solve the entire program and problem, it begins to stabilize the situation. In many of your areas, the percent of government contributions to Medicare+Choice relative to fee-for-service will decline below 80 percent. You can't run a program that way. You can't possibly fulfill the promises that you have made to beneficiaries, and I urge you to look very carefully at that.

I also urge you to reexamine the entire regulatory environment. Before me, I have these regulations that came out, the mini reg and the operational policy letters. This is all in the last year. Here are our comments. We've commented on everything. There is virtually an operational policy letter every week.

In every one of our comments, we have not once taken issue with patient protection matters. We have taken serious issue with administrative issues.

I would conclude, Mr. Chairman—and there is so much to say—I would conclude by saying the following. There are three factors that plans report are problematic in proceeding forward in this program, and I hope that you will take a very serious look at them. The first is a relationship between Medicare+Choice payments and fee-for-service payments, and there is a problem.

The second is the broad regulatory environment. We no longer have a level playing field. Our providers are telling us daily that the amount of regulation here simply makes it impossible for them to continue to participate in this program relative to the traditional program.

And, finally, we find that many of our plans around the country are raising the very serious issue that I think will be a major topic for discussion in this committee about the wisdom of continuing on a path where, in fact, the regulator is the competitor.

We have a serious issue with that. There are very good people over at HCFA. We work with them very closely, despite our disagreements on many of the technical issues we're here to talk to you today. But the fact is you can't run a railroad this way, and the beneficiaries stand to lose a great deal.

I hope that won't happen, and we would like to work with you on a bipartisan basis to fix it, to address it. We think the window is now, and if you don't act this year we look forward to far more beneficiaries being affected, and no one wants that.

Thank you, Mr. Chairman.

[The prepared statement of Karen Ignagni follows:]

PREPARED STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO, AMERICAN ASSOCIATION OF HEALTH PLANS

I. INTRODUCTION

The members of the American Association of Health Plans (AAHP) appreciate the opportunity to submit testimony to assist in the Subcommittee's evaluation of the Medicare+Choice program. AAHP represents more than 1,000 HMOs, PPOs, and similar network health plans; our membership includes the majority of Medicare+Choice organizations, which collectively serve more than 75 percent of beneficiaries in the Medicare+Choice program. Together, AAHP member plans provide care for more than 150 million Americans nationwide and have strongly supported efforts to modernize Medicare and give beneficiaries the same health care choices that are available to working Americans.

Our plans have had a longstanding commitment to Medicare and to the mission of providing high-quality, comprehensive, cost-effective services to beneficiaries. Today, more than 17 percent—or 6.2 million beneficiaries—are enrolled in health plans, up from only six percent just five years ago. Recent research indicates that health plans are attracting an increasing number of older Medicare beneficiaries, and that Medicare beneficiaries are remaining in health plans longer. In addition, near-poor Medicare beneficiaries are more likely to enroll in health plans than higher-income beneficiaries. These health plans offer Medicare beneficiaries many benefits that are not covered under fee-for-service Medicare, such as full year's hospitalization, lower copayments and deductibles, and prescription drug coverage (Figure 1).

	Medicare+Choice	Fee-for-Service
Outpatient Prescription Drug Coverage	Yes	No
Deductible for Physician Visits	No	Yes
Nominal Copayment for Physician Visit	Yes	No
Hospital Inpatient Cost-Sharing	Typically, No	Yes
Annual Day Limit on Hospital Coverage	Typically, No	Yes

With passage of the Balanced Budget Act (BBA) two years ago, Congress took significant steps toward the goal of providing Medicare beneficiaries with expanded coverage choices similar to those available in the private sector and toward ensuring the solvency of the Medicare trust fund. The establishment of the Medicare+Choice program was supported by AAHP and regarded as the foundation for moving forward with a program design that can be sustained for future generations of Medicare beneficiaries. Unanticipated events, however, have endangered this foundation and created structural issues that must be resolved quickly.

II. CURRENT STATE OF THE MEDICARE+CHOICE PROGRAM

As members of the Subcommittee know, the first public sign of trouble in the Medicare+Choice program surfaced last fall when nearly one hundred health plans were forced to reduce or end their participation in the program, resulting in more than 400,000 beneficiaries losing their health plan choice. Fifty thousand of these beneficiaries were left with no other health plan option. At that time, AAHP and others urged the Administration and Congress to make mid-course corrections, arguing that if program problems were left unaddressed, more health plans, many of which have participated in the program for years, would face the same difficult decisions in 1999 and beyond. The unfortunate reality is that we were right. Just two weeks ago, the Health Care Financing Administration (HCFA) announced that 327,000 beneficiaries in another ninety-nine health plans would lose their health plan on January 1, 2000. Of the 327,000 affected beneficiaries, 70,000 will have no choice but to return to the fee-for-service program because there is no other Medicare+Choice plan in their area.

In addition to these sobering events, an AAHP survey of its 26 largest members that participate in the Medicare+Choice program showed that among responding organizations, a substantial number of beneficiaries who will be able keep their plan next year will face increased out-of-pocket costs and reductions in benefit levels. Survey results, which were independently collected and tabulated by Peter D. Hart Research for AAHP, showed that premium changes to be instituted by 18 companies will affect nearly 1.5 million of the 3.86 million beneficiaries covered by the survey whose plans will remain in the program next year. Among these individuals, monthly premiums will increase by $20 or more for 926,009 persons and $40 or more for 400,757 of the 926,009 persons. Monthly premiums will decrease for just fewer than 12,000 individuals; in all instances, these decreases will be less than $20. More than 1.3 million enrollees will face an increase in prescription drug copayments, while just 10,000 enrollees will have decreased prescription drug copayments next year. Additionally, about 600,000 individuals covered by the survey will face hospital inpatient copayments averaging $275 next year.[1]

III. SOURCES OF MEDICARE+CHOICE PROGRAM INSTABILITY

The health plans that announced their decisions to leave the Medicare+Choice program or to reduce benefits did not make their decisions lightly. Many of these plans worked up to the July 1st deadline to devise strategies that would enable them to maintain their current service area, to stay in the program next year, or to minimize benefit reductions. But for many of these plans, current problems with the Medicare+Choice payments and increased regulatory burdens were too overwhelming, and they were forced to reduce their participation, to withdraw from the program or to scale-back benefits.

Medicare+Choice Payment

The BBA limited the annual rate of growth in payments to health plans, producing $22.5 billion in savings from the Medicare+Choice program. In addition, the BBA reduced geographic variation in payments to encourage the development of coverage choices in areas of the country with lower payments.

We supported the passage of payment reforms in the BBA and understood the need to contribute our fair share toward the savings necessary to stabilize the Medicare Trust Fund. We are deeply concerned, however, that unintended consequences of higher than anticipated inflation, the growing gap in funding between the Medicare+Choice and fee-for-service sides of the program, and administrative actions taken by HCFA affecting Medicare+Choice payments do not serve the best interests of beneficiaries and were not anticipated by Congress.

In 1998 and 1999, because of the low national growth percentage and the inability to achieve budget neutrality, no counties received blended payment rates. Spending on medical services furnished to Medicare-eligible military retirees by Department of Veterans Affairs (VA) and Department of Defense (DoD) hospitals continues to be omitted from the calculation of Medicare+Choice rates. A few years ago, the Prospective Payment Advisory Commission (ProPAC) estimated that health care pro-

[1] In responding to the survey, plans were asked to provide information on the benefit arrangement that presently applies to the largest share of their Medicare+Choice enrollees. Plans were asked to describe the 1999 benefit, any change in the benefit to become effective on January 1, 2000, and the number of enrollees covered under the benefit. Using this information, Peter D. Hart Research estimated the number of enrollees affected by benefit changes and the magnitude of these changes among the subset of enrollees covered by the most common benefit arrangement. Not all companies responded to each question.

vided in DoD and VA facilities to Medicare beneficiaries accounts for 3.1 percent of the total resource costs of treating Medicare beneficiaries. ProPAC concludes from its findings that the omission of the cost of care provided in DoD and VA facilities to Medicare beneficiaries leads to systematic errors in both the level and distribution of Medicare managed care payments. H.R. 2447, introduced by Congressman McDermott, would help address this problem by including these amounts in Medicare+Choice rate calculations.

In addition, the BBA sought to begin tackling some of the issues related to Graduate Medical Education (GME) reform by limiting the number of residents supported by the Medicare program and by providing incentives to hospitals to reduce the size of their training programs. However, a central BBA provision, the removal of GME funds from the calculation of payments to Medicare+Choice organizations, does not appear to address GME reform goals. AAHP opposed the removal of GME funds from the calculation of Medicare+Choice payments, particularly in the absence of broader, structural reforms to GME financing. AAHP voiced concern that removal of GME funds could result in premium increases and/or benefit reductions for beneficiaries enrolled with plans already participating in the program, inhibit enrollment growth, and at worst could force some plans to leave the program.

This provision was intended to assure that beneficiaries have access to services at these facilities and that these facilities are compensated for their teaching costs. Studies show that health plan members do use teaching facilities and that plan payments for a given case in a teaching hospital greatly exceed payments for the same case in a non-teaching hospital. Although GME payments are being removed from Medicare+Choice payments, in many markets, the dominance of teaching hospitals limits health plans' ability to reflect the carve-out by making commensurate reductions in payments to teaching hospitals. Consequently, teaching hospitals are receiving GME payments from the Medicare program as well as higher payments from health plans. Ultimately, it is the Medicare beneficiary who bears the burden of these higher payments due to reductions in additional benefits that they otherwise would receive.

Furthermore, HCFA has chosen to implement its new risk-adjustment methodology in a manner that will cut aggregate payments to Medicare+Choice organizations by an estimated *additional* $11.2 billion over a five-year period beginning in 2000. This is an administratively imposed increase in the $22.5 billion savings Congress expected from the payment methodology as enacted in the BBA. In fact, at the time of the BBA's approval, **the Congressional Budget Office (CBO) did not score the new risk-adjuster as saving money.** More recently, CBO stated that it had "previously assumed" that the health status-based risk-adjustment in the Medicare+Choice program would be budget neutral.[2]

AAHP analysis of PricewaterhouseCoopers projections of Medicare+Choice rates in each county over the next five years shows that a significant gap opens up between reimbursement under the fee-for-service program and reimbursement under the Medicare+Choice program.[3] This Medicare+Choice Fairness Gap will be at least $1,000 for two-thirds of Medicare+Choice enrollees living in the top 100 counties, as ranked by Medicare+Choice enrollment (Figure 2). This same Fairness Gap will exceed $1,500 per enrollee in major Medicare+Choice markets, including Chicago, Los Angeles, Miami, New York, Boston, Pittsburgh, Cleveland, St. Louis City, Dallas, and Philadelphia. In Miami, the Fairness Gap will be $3,500 per enrollee in 2004 and in Houston the gap will exceed $2,500 per enrollee in 2004. In New Orleans, the Fairness Gap will exceed $2,600 per enrollee in 2004.

For nearly half of Medicare+Choice enrollees living in the top 100 counties, government payments to health plans on behalf of beneficiaries will be 85 percent or less of fee-for-service Medicare payments in 2004, significantly exceeding estimates of so-called overpayment due to favorable selection by plans (Figure 3). When AAHP examined the top 101 to 200 counties as ranked by enrollment, we continued to find a large Fairness Gap in the smaller markets that plans were expected to expand into under the policy changes implemented by the BBA. In these counties, nearly

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[2] "An Analysis of the President's Budgetary Proposals for FY 2000," Congressional Budget Office.

[3] AAHP calculation from PricewaterhouseCoopers (PWC) analysis prepared for AAHP, March 1999. AAHP's analysis produces conservative estimates of the Fairness Gap by assuming that county-level Medicare+Choice and FFS payments were equal in 1997, even though Medicare+Choice payments were actually lower than FFS per capita payments in 1997. PWC analysis based on first stage of risk adjustment. PWC analysis does not reflect second stage of risk adjustment, which HCFA expects to reduce payments by an additional 7.5 percent in 2004. The Fairness Gap represents growth between 1997 and 2004 in the projected difference between county-level aged Medicare+Choice risk-adjusted per capita payments and FFS per capita payments. Top 100 counties by enrollment account for 72 percent of enrollment.

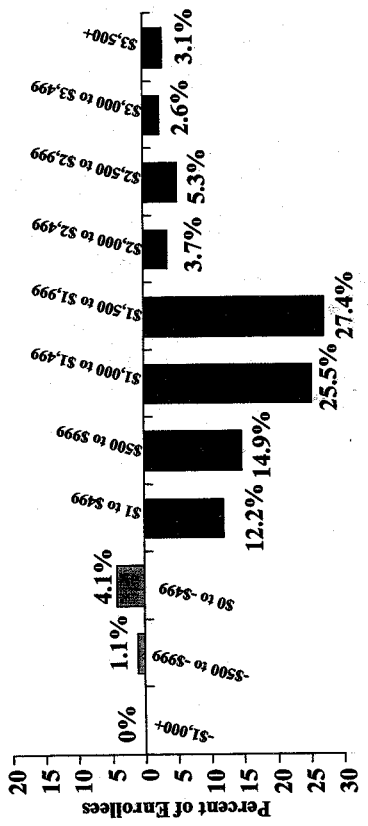
half of Medicare+Choice enrollees live in areas where the Fairness Gap will be $1,000 or more in 2004.

A large percentage of the Fairness Gap is attributable to HCFA's new risk-adjuster, the design of which is severely flawed. Rather than measuring health-status, HCFA's risk-adjustment measures inpatient hospital utilization. This design penalizes health plans that use disease management programs designed to reduce hospitalizations for chronically ill patients who would have otherwise been treated in inpatient settings. These programs are designed to prevent costly hospitalizations by treating patients in alternative settings.

An AAHP analysis of PricewaterhouseCoopers projections that incorporate the effect of the risk-adjustment methodology, when it is phased-in at 10 percent, indicate that nearly half of current Medicare+Choice enrollees live in areas in which year 2000 payments will increase by 2 percent or less over 1999 payments. This situation will likely worsen in 2001 when HCFA will base 30 percent of Medicare+Choice payments on its risk-adjustment methodology. Contrary to ensuring predictability in the new Medicare+Choice program, the impact of this risk-adjustment methodology will be to restrict new market entrants and leave beneficiaries with fewer options, reduced benefits and higher out-of-pocket costs. AAHP has found that the impact of HCFA's risk-adjuster on Medicare+Choice payments to rural and urban counties is similar—rural areas with Medicare+Choice beneficiaries are cut by about 6 percent, while urban areas are cut by about 7 percent.

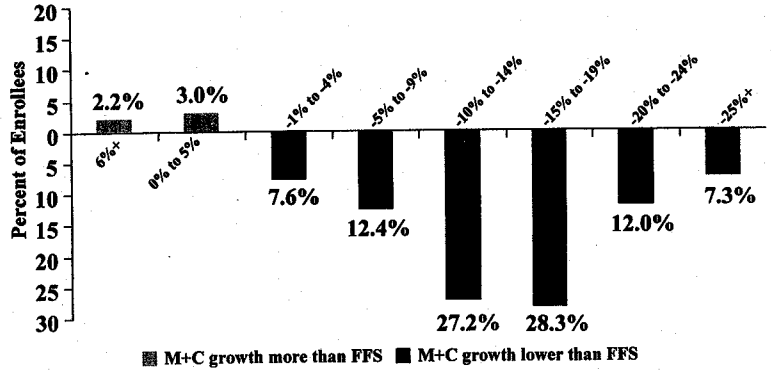
AAHP also has significant concerns about the funding of the Medicare beneficiary information campaign. While it is reasonable for health plans and their enrollees to contribute to funding HCFA's education and information dissemination initiatives, their contribution should be in proportion to their participation in the Medicare program. Last year, Medicare risk HMOs and their enrollees represented 14.3 percent of the program, but shouldered 100 percent of the cost of the information campaign.

Figure 2: The Fairness Gap--Top 100 Counties By Enrollment
Two-Thirds of M+C Enrollees Live In Areas Where
The Fairness Gap Will Be $1,000 Or More In 2004



Source: AAHP calculation from PricewaterhouseCoopers (PWC) analysis prepared for AAHP, March 1999. PWC analysis based on first stage of risk adjustment. PWC analysis does not reflect second stage of risk adjustment, which HCFA expects to reduce payments by an additional 7.5 percent in 2004. The Fairness Gap represents growth between 1997 and 2004 in the projected difference between county-level aged Medicare+Choice risk-adjusted per capita payments and FFS per capita payments. Top 100 counties by enrollment account for 72 percent of enrollment.

Figure 3: The Fairness Gap --Top 100 Counties By Enrollment
Nearly Half of M+C Enrollees Live In Areas Where The Fairness Gap Will Be 15 Percent Or More In 2004



Source: AAHP calculation from PricewaterhouseCoopers (PWC) analysis prepared for AAHP, March 1999. PWC analysis based on first stage of risk adjustment. PWC analysis does not reflect second stage of risk adjustment, which HCFA expects to reduce payments by an additional 7.5 percent in 2004. The Fairness Gap represents growth between 1997 and 2004 in the projected difference between county-level aged Medicare+Choice risk-adjusted per capita payments and FFS per capita payments. Top 100 counties by enrollment account for 72 percent of enrollment.

The FY1999 $95 million funding level represents an annual cost of **$2.40** per beneficiary if it is spread over the entire Medicare population of 39 million beneficiaries. It represents an annual cost of **$15.43** per beneficiary if it is spread over only those beneficiaries who have enrolled in a Medicare+Choice plan. On average, generating the $95 million authorized by the BBA will require a tax of $1.90 each month for each beneficiary enrolled in a Medicare+Choice plan (the tax is collected over only the first nine months of the year). This $1.90 per month per beneficiary tax represents 18% percent of the average monthly 1998 to 1999 payment increase under the new BBA payment methodology.

AAHP supports the goal of providing beneficiaries with accurate information that allows them to compare all options and select the one that best meets their needs. Last year's campaign did not meet Congressional expectations. Many beneficiaries received incorrect or confusing information and some plans were left out of the brochure altogether. AAHP urges Congress to ask HCFA for an accounting of its use of resources for educational purposes. We also urge Congress to adopt MedPAC's recommendation to fund this program through HCFA's operating funds rather than a tax on Medicare+Choice enrollees. AAHP continues to believe that the entire beneficiary information program should be reevaluated and streamlined.

HCFA documents indicate that it has $25 million left from the fees collected last year and has indicated that next year's appropriation should be offset by this amount. Yet, HCFA is asking for more in new user fees than the amount collected last year. Given concerns about the effectiveness of this effort and at a time of growing instability in the Medicare+Choice program, we strongly urge that the program be scaled back and realistic goals set. In addition, we urge that the cost of a redesigned effort be distributed proportionately across the entire system.

Stabilizing Payment Will Help Stabilize the Medicare+Choice Program

The present state of the Medicare+Choice program is not what Congress expected when the BBA was approved two years ago. Rather than having expanded coverage choices, beneficiaries face fewer coverage choices. Additional benefits offered by plans that are not available in the fee-for-service program are being jeopardized. Some have argued that HCFA overpays health plans and that plans withdrawing from the market are simply making "business decisions." In response, first let me say this: overpaid health plans do not leave a market. Overpaid health plans do not reduce benefits. Second, payment and regulatory requirements dictate the type of environment in which health plans participate in the Medicare+Choice "business." So yes, the current payment and regulatory environment is forcing plans to make difficult business decisions regarding their participation in the Medicare+Choice program.

The Bilirakis-Deutsch bill, H.R. 2419, would go a long way toward stabilizing the payment situation in both urban and rural areas by requiring that HCFA implement the new risk-adjuster on a budget-neutral basis, which is in keeping with Congressional intent. The bill also would ensure that national updates to government payments for beneficiaries choosing a Medicare+Choice plan grow at the same rate as government payments for beneficiaries choosing fee-for-service Medicare. H.R. 2419 represents an equitable restoration of funding by increasing the total dollars available in setting Medicare+Choice payment rates. This approach will help ensure that the BBA goal of expanding coverage choices for all beneficiaries is met.

Another way that payments could be stabilized is through establishment of a true payment floor. As discussed earlier in this testimony, Medicare+Choice payments are falling drastically relative to fee-for-service Medicare payments—in many areas, payments are falling to 80 percent or less of fee-for-service payment. To prevent this, a true floor could be set such that Medicare+Choice payments would not fall below a specified percentage of fee-for-service per capita payments in a county.

Medicare+Choice Regulatory Environment Contributes to Program Volatility

The challenges facing the Medicare+Choice program do not result from payment alone. HCFA's approach to overseeing the program and the structure of the Medicare+Choice program are contributing to the volatility in the program. Taken together, the issues of payment and regulation have challenged plans' abilities to maintain their health care networks. In some cases, providers simply have told health plans that given low payments and increased regulatory requirements on them, that they are better off just seeing beneficiaries under the fee-for-service program.

HCFA Roles as Purchaser and Regulator in Conflict. HCFA's dual roles as purchaser and regulator are, at times, in conflict. Nowhere has this conflict been more evident than in HCFA's implementation of the BBA. The situation plans faced in the fall of 1998 serves to illustrate the inherent conflict between HCFA's tradi-

tional role as a regulator and its changing role as a purchaser. HCFA published the Medicare+Choice regulation, which was more burdensome than expected, nearly a month and a half after the date plans were required to file their 1999 adjusted community rate proposals (ACRs) last year.

This situation and the unrealistic compliance deadlines combined with the reduced rate of increase in payments and the uncertainty created by the new risk-adjustment model, caused plans across the country and across model types to become deeply concerned last fall about the viability of the benefits and rates included in their ACRs on the originally mandated May 1st deadline. This led our members to make an unprecedented request to HCFA to allow plans to resubmit parts of their ACRs. In some service areas, the ability to vary copayments—even minimally—meant the difference between a plan's ability to stay in the Medicare+Choice program or to pull out of a market.

While this request presented HCFA with a complicated situation, AAHP strongly believes that an affirmative decision would have been better for beneficiaries. As a purchaser, HCFA had a strong motivation to maintain as many options as possible for beneficiaries by responding to health plans' concerns and adopting a more flexible approach to Medicare+Choice implementation. As a regulator, however, HCFA had concerns about criticism that could result from reopening bids, and thus chose not to allow any opportunity for adjustment of ACRs. HCFA's decision in part contributed to the withdrawal of nearly 100 health plans from the program, affecting more than 400,000 beneficiaries. These role conflicts remain unresolved, even largely unaddressed. Until ways are found to reconcile them, however, they will stand in the way of designing and delivering a Medicare+Choice program that really works for beneficiaries.

Need For Fair Regulations. Beneficiaries should have confidence that all options, including both Medicare+Choice plans and the Medicare fee-for-service program, meet standards of accountability that ensure that they will have access to all Medicare benefits and rights regardless of the coverage choice they make. All Medicare+Choice options offered to Medicare beneficiaries should be required to meet comparable standards in such areas as quality of care, access, grievance procedures, and solvency.

These standards should be implemented through regulatory requirements that make the best use of plans' resources to ensure that beneficiaries receive the maximum value from the program. This means that when requirements are established, their benefits must outweigh their costs. While we appreciate HCFA's efforts to address concerns about certain aspects of the Medicare+Choice regulation over the past several months, the fact remains that health plans are having to devote substantial human and financial resources toward compliance activities, which in turn means fewer resources devoted to additional benefits.

AAHP renews its request that HCFA undertake an immediate analysis to develop a full understanding of the relationship between the costs associated with the full array of Medicare+Choice requirements and their value to beneficiaries and the Medicare program. We believe strongly that more of these resources should be available for benefits and patient care.

Specific Areas of Concern with Medicare+Choice Legislative and Regulatory Requirements. Beyond the issues presented above the following specific areas are among those that remain problematic:

- **Discontinuation of Flexible Benefits Policy.** Prior to enactment of the BBA, Medicare HMOs were allowed to vary premiums and supplemental benefits within a contracted service area on a county-by-county basis, and to customize products—or offer "flexible benefits"—to meet beneficiary and employer needs and the dynamics of individual markets. The BBA and HCFA's Medicare+Choice regulations are both more restrictive than this policy, and require that Medicare+Choice plans offer uniform benefits and uniform premiums across a plan's total service area without regard to different county payment levels. The result is that plans are less likely to continue or begin serving lower-payment counties, just the opposite of expanding coverage choice. HCFA developed a transition policy for existing contractors, which allows Medicare+Choice organizations to segment service areas and offer multiple plans in an effort to mitigate the effect of moving away from the flexible benefits policy. While this transitional relief has alleviated this problem in the short term, a permanent solution is needed. AAHP encourages the Committee to revise the statute so as to revert to the prior policy allowing flexible benefits within plan service areas.
- **HCFA's QISMC Standards Disregard Experience of Private Sector.** One area of significant concern to AAHP member plans is HCFA's Quality Improvement System for Managed Care (QISMC). QISMC is designed to establish a consistent set of quality oversight standards for health plans for use by HCFA

and state Medicaid agencies under the Medicare and Medicaid programs, respectively. AAHP has long advocated coordination of quality standards for health plans in order to maximize the value of plan resources dedicated to quality improvement. While AAHP believes that QISMC could have been designed to contribute to this important goal, our members have a number of serious concerns regarding HCFA implementation of this program. Furthermore, we are also concerned that the Medicare program is not providing equal attention to the overall quality of care furnished under the fee-for-service program.

One of our primary concerns is that QISMC lacks clear coordination with existing public and private sector accreditation and reporting standards. Rather than coordinate with existing standards, QISMC establishes an entirely new system of requirement that not only are far more stringent, but also are unreasonable in their timeframes. Meeting two competing sets of standards adds to administrative cost while detracting from health care quality improvement.

IV. SOLVING THE PROBLEMS THAT UNDERMINE THE SUCCESS OF THE MEDICARE+CHOICE PROGRAM

AAHP and its members applaud the Subcommittee for holding this hearing and implore the Subcommittee to move immediately in taking measures to restore stability to the Medicare+Choice program. In doing so, AAHP members urge the Subcommittee to consider the following four principles.

First, Congress must ensure that Medicare+Choice payments are adequate and stable and that they are comparable to those in fee-for-service Medicare. Federal contributions to Medicare+Choice organizations should be adequate and predictable to promote expanded coverage choices for beneficiaries in low payment areas, while maintaining the availability of affordable options for beneficiaries in markets in which health plan options are currently well established.

The Administration projects that its approach will cut Medicare+Choice payments by an additional $11.2 billion over a 5-year period and thus endanger the very choices, broader benefits, and out-of-pocket protections these beneficiaries enjoy. As is now apparent, the BBA payment formula, in combination with the Administration's new risk-adjuster, will not achieve this goal. Instead, AAHP analysis shows a dramatic gap opening up between payments for beneficiaries in the Medicare+Choice program and their counterparts in fee-for-service Medicare.

AAHP urges of swift approval of the bipartisan H.R. 2419, the Medicare+Choice Risk-Adjustment Amendments of 1999, introduced by Congressman Bilirakis and Congressman Deutsch. A budget-neutral risk-adjuster brings greater equity to payments without penalizing plans or destabilizing the program.

Second, HCFA's beneficiary information and education effort should be re-examined and refocused to meet beneficiary interests and needs. AAHP supports the goal of providing beneficiaries with accurate information that allows them to compare all options and select the one that best meets their needs. AAHP urges Congress to ask HCFA for an accounting of its use of resources for educational purposes. AAHP continues to believe that the entire beneficiary information program should be reevaluated and streamlined.

Third, Congress must promote and enforce a responsive regulatory environment. Without a doubt, the present instability has undermined beneficiaries' confidence in the Medicare+Choice program. Unless action is taken to restore their confidence, it is unlikely that the goals of the BBA will be achieved. Beneficiaries deserve a well-run program that is responsive to their needs. Unfortunately, the conflict between HCFA's roles as a purchaser and regulator often prevent the Agency from acting more nimbly in the best interests of beneficiaries.

HCFA's implementation of the BBA highlights the tension between these roles. To increase consumer confidence in all aspects of the Medicare program, HCFA should take immediate steps to improve administration and regulation of the Medicare+Choice program. During the first year of Medicare+Choice implementation, HCFA promulgated more than 800 pages of new regulations and issued countless operational policy letters. The Medicare+Choice regulation should be re-examined to ensure that the value to beneficiaries justifies the resources required for compliance.

V. CONCLUSION

For over a decade, health plans have delivered to beneficiaries coordinated care, comprehensive benefits, and protection against highly unpredictable out-of-pocket costs, but these coverage choices are at risk. Congress and the Administration should act immediately to create a level playing field between the payments under the Medicare+Choice program and the Medicare fee-for-service program, and a regu-

latory environment based on the principles of ensuring that the value to beneficiaries justifies the resources required for compliance and equal accountability under the Medicare+Choice and Medicare fee-for-service programs.

We urge you to address the Fairness Gap, and the problems we have identified with HCFA's implementation of the Medicare+Choice risk-adjuster, and with regulation of the program. We are in the process of conferring with the members of the Subcommittee and your staff about AAHP's specific suggestions—some of which we have mentioned today—for solving these problems.

Our concern last year that without action, more beneficiaries would lose access to their plan and that others would face reductions in benefits has become a dismal reality. Further delay could render the Medicare+Choice program beyond repair or salvage. This outcome would be a loss not only for the beneficiaries who have chosen a Medicare+Choice plan, but also for future beneficiaries who would be denied the opportunity to do so.

Mr. BILIRAKIS. Thank you very much, Ms. Ignagni.

Mr. Powell?

STATEMENT OF JOHN POWELL

Mr. POWELL. Thank you, Mr. Chairman, for the opportunity to testify today.

The 3 million members and supporters of the Seniors Coalition are grateful to you for your excellent leadership of this subcommittee and we appreciate the diligent and thoughtful work of its members and staff in helping to find solutions to the many critical issues that are facing older Americans.

The enactment of Medicare+Choice was an historic first step in giving seniors access to the kinds of health care options available to other Americans. Seniors want choice and they want freedom from one-size-fits-all program. Thus, the importance of the passage of Medicare+Choice legislation cannot be overstated, and that's why we are so disappointed that its promise has not been fully realized.

When Medicare was created in the 1960's, the U.S. was facing a situation which had no precedent. For the first time, large numbers of people were growing old before they died, and we were not equipped to address their health care needs.

Moreover, understanding of the process of aging was limited. Most believed that the loss of mental faculties was a natural part of aging. We thought Medicare must be based upon a structure that would act in a decisionmaking role for beneficiaries who could not act on their own behalf.

We, of course, now know that assumption was incorrect. Critical thinking skills do not necessarily diminish with age, and the vast majority of older Americans remain sharp of mind throughout their lives.

But, unfortunately, we created a bureaucratic structure, the Health Care Financing Administration, which was built upon this age's theory and which still operates on that basis today.

Then there are the changes in the practice of medicine. When Medicare began, there had never been a heart transplant. There were no medicines for high cholesterol. Patients spent weeks in bed recovering from cataract surgery, and the concept of an artificial bone joint belonged in the realm of science fiction.

Now, medicine has increasingly been focused upon the prevention of disease, not just upon treatment of acute illness. Eye surgery is performed in shopping malls, and inpatient hospital care is

the exception, not the rule, for not only the treatment of many illnesses, but even for many types of surgery.

The enactment of Medicare+Choice was a major step in helping Medicare accommodate itself to the realities of aging and the practice of Medicare in the late 20th century, or so it was intended to be, but 2 years later it still has not fulfilled its promise. There are not hundreds of new entrants into the Medicare marketplace. Why not?

The answer, we believe, lies in the seemingly endless succession of barriers that have prevented full implementation of Medicare+Choice.

First, consider the fact that HCFA took over 1 year from the passage of BBA to publish the 833 pages of regulations which laid down the ground rules. With barely 2 months left to submit proposals, the initial deadline of last August 31st went by with barely a nibble.

Then there is the question of performance standards. Many insurers had no structure for collecting the type of data required, not to mention the fact that such data collection and management would require that some plans rewrite all of their existing contracts with providers.

Now, a year later, the situation is no better. Rather than a stampede of plans seeking to enter the market, there are, in fact, plans retreating from it, and we now know that is due in part to HCFA deciding to squeeze an extra $11 billion from those very plans that were supposed to be encouraged to enter the market.

Choice and competition are two sides of the same coin. Without competition there is no choice. But neither can survive where there is no incentive. HCFA, one might argue, not only removed the carrot of incentive, but also added far too many sticks.

Earlier this year the Seniors Coalition had the opportunity to testify before this subcommittee on risk adjustment methodology for Medicare+Choice payment. We said then that we were gravely concerned that HCFA had chosen to base the risk adjustment upon an outdated approach to the practice of medicine. We were concerned, of course, that plans would not be adequately compensated for treating Medicare beneficiaries in outpatient settings and that this would result in increased incidence of hospitalization or in plans leaving the program.

And, just like CBO, we did not expect the new risk adjustment system to change the overall payment level for such plans.

H.R. 2419, the Medicare+Choice Risk Adjustment Amendments of 1999, is a major step toward stemming the tidal wave of plans leaving Medicare+Choice, and the Seniors Coalition supports it. It restores the original intent of Congress by requiring the establishment of a fair method for risk adjustment calculation. Finally, and most importantly, it will help restore the original intent of Congress in its passage of plus-Choice, the empowerment of the Medicare beneficiary as a health care consumer.

[The prepared statement of John Powell follows:]

PREPARED STATEMENT OF JOHN POWELL, VICE PRESIDENT, GOVERNMENT AFFAIRS, THE SENIORS COALITION

Thank you, Mr. Chairman, for the opportunity to testify today. The three million members and supporters of The Seniors Coalition are grateful to you for your excel-

lent leadership of this subcommittee. We appreciate the diligent and thoughtful work of its members and staff in helping to find solutions to the many critical issues affecting the health of older Americans.

The Seniors Coalition believes that the enactment of Medicare+Choice was an historic first step in giving seniors access to the kinds of health care options available to other Americans. Seniors want choice, they want freedom from a one-size-fits all program that only offers the same benefits to everyone regardless of their needs or circumstances. Thus, the importance of the passage of Medicare+Choice legislation cannot be overstated, and that is why we are so disappointed that its promise has not been fully realized.

To explain this, I would first like to speak for a moment about the history of Medicare. When Medicare was created in the mid-1960s, the United States was facing a situation that had no precedent. For the first time in the history of the world, large numbers of people were growing old before they died, but neither our economy nor our society was equipped with programs to address their health care needs. Thus, Medicare came into being.

But it is important to make two more points about the historical context in which Medicare was created. First, in the mid-1960s, our understanding of the process of aging was very limited. Most believed that loss of mental faculties were a natural part of aging and that, to be useful and effective, Medicare must be based upon a structure that would act in a decision making role for beneficiaries who could not act upon their own behalf. Of course, we now know that assumption was wrong very wrong. Critical thinking skills do not necessarily diminish with age, and the vast majority of older Americans remain sharp of mind throughout their life. But, unfortunately, we created a bureaucratic structure, the Health Care Financing Administration (HCFA), which was built upon this archaic and ageist theory, and which still operates on that basis today.

Second, consider the changes in the practice of medicine that have occurred in the last 35 years! When Medicare began, there had never been a heart transplant; there were no medications for high cholesterol, had we even understood its impact on the cardio-vascular system; patients spent weeks in bed, flat on their back, recovering from cataract surgery; and the concept of an artificial bone joint belonged to the realm of science fiction. Now, medicine is increasingly focused upon the prevention of disease not just upon treatment of acute illnesses; eye surgery is performed in shopping malls; and inpatient hospital care is the exception, not the rule for not only the treatment of many illnesses but even for many types of surgery.

The enactment of Medicare+Choice was a major step in helping Medicare accommodate itself to the realities of aging and the practice of medicine in the late 20th century—or so it was intended to be. But, two years later, it has not fulfilled its promise. There are not hundreds of new entrants into the Medicare marketplace; far too many beneficiaries do not have the luxury of choosing from among a number of options. And why not? The Seniors Coalition does believe that increased choice was clearly the intent of the Congress. Thus we need to look elsewhere to find the reason.

The answer, we believe, lies in the seemingly endless succession of barriers that have prevented full implementation of the Medicare+Choice program. First, consider the fact that HCFA took over a year to publish the 833 pages of regulations which laid down the ground rules by which insurers could enter the Medicare market. With barely two months to submit proposals, the initial deadline of last August 31 went by with barely a nibble.

Then, there was the question of performance standards. Many insurers had no structure for collecting the type of data required, not to mention the fact that such collection and management would require that some types of plans rewrite all of their existing contracts with providers.

And now, a year later, the situation is no better. Rather than there being a stampede of plans seeking to enter the market, there are, in fact, plans retreating from it. And, we now know, that is in no small way related to yet another hurdle, the fact that HCFA has decided to squeeze out $11 Billion over the next five years from the very plans that Medicare+Choice was created to encourage to enter the senior market.

Choice and competition are two sides of the same coin. Without competition there is no choice. But neither can survive where there is no incentive. HCFA, one might argue, not only removed the carrot, but also added far too many sticks.

Earlier this year, The Seniors Coalition had the opportunity to testify before this subcommittee on the risk adjustment methodology for Medicare+Choice payment rates. We said then that we were gravely concerned that HCFA had chosen to base them upon an outdated approach to the practice of medicine. We were concerned, of course, that plans would not be adequately compensated for treating Medicare

beneficiaries in outpatient settings—and that this would result increased incidences of hospitalization of Medicare beneficiaries or in plans leaving the program. And, just like CBO, we also did not expect that this new risk adjustment system would change the overall payment levels for such plans.

While we still believe that HCFA will take far too long to begin using a variety of data for risk calculations, HR 2419 is a major step toward stemming the tidal wave of plans leaving Medicare+Choice, and we give it our support. It restores the original intent of Congress when it required the establishment of a new method for risk adjustment calculation. And finally, and most importantly, it will help to restore the original intent of the Congress in its passage of Medicare+Choice the empowerment of the Medicare beneficiary as a healthcare consumer.

Mr. BILIRAKIS. Thank you, Mr. Powell.

Ms. Canja?

STATEMENT OF ESTHER CANJA

Ms. CANJA. Mr. Chairman, I am Tess Canja, president of AARP. Thank you for the opportunity to share with you the beneficiary perspective on the Medicare+Choice program and the future of Medicare.

In 1997, Congress created and AARP supported Medicare+Choice to introduce greater competitiveness into Medicare and to offer beneficiaries more health plan options.

As this legislation passed, we understood that extending the short-term solvency of the Medicare program required shared sacrifice from all who have a stake in Medicare—providers and beneficiaries, alike. We also recognized that Medicare+Choice would lay the foundation for essential longer-term reform in Medicare.

But change never comes easy. This year, 99 Medicare+Choice plans announced that they will not renew or that they will reduce their service areas beginning in January of the year 2000. This will affect over 300,000 beneficiaries.

Further, and probably of even greater impact next year will be the number of Medicare HMOs that reduce their level of benefits and increase cost-sharing by beneficiaries.

AARP is deeply concerned about the dislocation HMO withdrawals will cause beneficiaries. All of these beneficiaries have the good fortune of still having Medicare, but the departure of Medicare HMOs from their areas means they will have fewer choices for their Medicare coverage, and, in many cases, higher out-of-pocket costs.

While only a little over 1 percent of those currently in Medicare+Choice will lose the option to enroll in managed care entirely, the impact on each beneficiary who is affected is 100 percent.

The HMO industry contends that the BBA payment rates are the chief reason that plans are pulling out of the Medicare market. AARP does not have enough data to evaluate whether the payments are adequate or fairly calculated, but such claims should be carefully reviewed to ensure that we don't return to an era of overpayments to some plans.

In this connection, Congress must continue to try to determine what the proper level of compensation for Medicare+Choice plans should be.

The initial implementation of Medicare+Choice offers several lessons. First, while private sector approaches have been able to address some glaring gaps in Medicare, namely the lack of prescrip-

tion drug coverage and out-of-pocket costs, these are not without their own failings. Beneficiaries enrolled in HMOs may be pleased with their lower costs and additional benefits; however, as we have seen, these beneficiaries will be exposed to the vagaries of the marketplace. They may not know from 1 year to the next whether their plan will remain a Medicare option.

Second, the impact of the BBA has been and will continue to be significant. It must be evaluated and understood before launching additional Medicare reforms.

I want to emphasize the importance of fully understanding the changes that have already been made under Medicare+Choice before we layer on new changes.

If Medicare reform legislation is pushed through too quickly before the effect on beneficiaries and the program is known, AARP would be compelled to alert our members to the dangers in such legislation and why we would oppose it.

Let me assure you, however, that AARP does not believe the status quo in Medicare is acceptable. To this end, my written statement identifies the fundamental principles that AARP believes should be the basis of any efforts to reform the program.

Mr. Chairman, AARP is committed to making Medicare stronger. We look forward to working with the committee and the Congress to improve the Medicare+Choice program and to carefully explore the best options for securing Medicare's future.

Thank you.

[The prepared statement of Esther Canja follows:]

PREPARED STATEMENT OF ESTHER "TESS" CANJA, PRESIDENT-ELECT, AARP

Good morning Mr. Chairman and members of the Committee. I am Tess Canja, President-elect of AARP. Thank you for this opportunity to share with you the beneficiary perspective on the Medicare+Choice program and the future of Medicare.

While this hearing is focused on evaluating the Medicare+Choice program and addressing its strengths and weaknesses, let me start by underscoring the enormous importance of Medicare. For over thirty years Medicare has provided dependable, affordable, quality health insurance for millions of older and disabled Americans. My home state of Florida has one of the largest beneficiary populations in the nation, and I see firsthand what a difference Medicare makes in the lives of older Americans. Medicare has been instrumental in improving the health and life expectancy of beneficiaries in Florida and across the nation. It has also helped to reduce the number of older persons living in poverty.

Medicare's promise of affordable health care extends beyond the current generation of retirees. Now, more than ever, Americans of all ages are looking to Medicare's guaranteed protections as part of the foundation of their retirement planning. AARP believes that in order for Medicare to remain strong and viable for beneficiaries today and in the future, we must confront the key challenges facing the program. Among these challenges are: keeping pace with advances in medicine and changes in health care delivery; and securing the necessary long-term financial stability for the program in light of the aging of the boomer generation.

To control the growth in Medicare expenditures and offer beneficiaries more health plan options, in 1997 Congress passed, and AARP supported, the Balanced Budget Act (BBA). The BBA provided significant program savings that extended Medicare's solvency until 2008; the recent report of the Medicare Trustees projected 7 additional years of solvency—to 2015. At the same time, the BBA addressed a number of problems with the Medicare managed care program. It modified the payment methodology for plans to address significant overpayment problems. It also made several major changes affecting the program's beneficiaries, including: the creation of the Medicare+Choice program through which new types of plans could participate in Medicare; formulation of new rules for when and how beneficiaries can enroll in health plans or Medigap plans; and requirements specifying the content of information beneficiaries receive about those choices. In addition, as a result of

the changes mandated by the BBA, virtually every beneficiary will face higher out-of-pocket expenses for health care.

AARP supported the BBA and its creation of Medicare+Choice in order to accomplish the objective of expanding choice in the program while also protecting access, affordability, and quality of health care services. We understood that extending the short term solvency of the Medicare program required shared sacrifice from all who have a stake in Medicare, including both providers and beneficiaries. We also recognized that Medicare+Choice would lay the foundation for essential longer term reform in the Medicare program.

Lessons Learned from Medicare+Choice

The challenges and successes of Medicare+Choice will have important implications for the next phase of Medicare reform. The initial implementation of Medicare+Choice offers several valuable lessons:

First, the significant withdrawals from the program by Medicare HMOs both this year and next serve as a wake-up call to all who seek to bring private sector solutions to bear on Medicare's problems. While some private managed care approaches have been able to help remedy some glaring gaps in original Medicare—namely, the lack of prescription drug coverage and high out-of-pocket costs—these are not without their own failings. When private businesses are given the authority to manage a beneficiary's care in exchange for the opportunity to earn a profit, several things can happen. On the positive side, the innovations in administrative efficiency and improved health care delivery may benefit the patient through lower costs, additional benefits, and better coordinated care. On the other hand, patients can be exposed to the vagaries of the market place. They may force instability in their benefits and premium charges, and worse yet, beneficiaries may not know from one year to the next whether their plan will remain a Medicare option. It is a challenge to separate the positive from the negative because the same factors create both results. A private business may be more innovative and efficient, yet in the absence of an opportunity to earn a profit, will leave (or not enter) the market. This dynamic is part of the market place—particularly for publicly traded companies who have a responsibility to their investors. The beneficiary who gained extra benefits in the short run may lose them in the long run. Congress anticipated this problem and provided some protections for beneficiaries who move back into original fee-for-service Medicare.

Second, with every change to Medicare, there are unintended consequences. Therefore, it is essential that policy makers and the public understand proposed changes to Medicare and their effect on beneficiaries, providers, and the Medicare program. This is especially important as the Congress moves forward on additional Medicare changes. There must be a careful and thorough examination of the full range of issues, including how the issues interact, as well as an understanding of the trade-offs that will be necessary.

The Breaux-Thomas premium support plan and the President's recent Medicare reform proposal provide opportunities for examining different reform options and for stimulating public debate. Genuine debate is critical to build public understanding and support for reform. AARP believes it would be a serious mistake for anyone to hinder debate or for Congress to rush to judgment on any reform option. *However, if reform legislation is pushed through too quickly, before the effects on beneficiaries and the program are known and before there is an emerging public judgment, AARP would be compelled to alert our members of the dangers of such legislation and why we would oppose it.*

Third, the significant number of Medicare HMO withdrawals has highlighted the difficulties older Americans have because outpatient prescription drugs are not included in Medicare's benefit package. Beneficiaries who seek drug coverage may find Medicare HMOs are not available in many locations. Those who do enroll in Medicare HMOs for drug coverage are finding that drug benefits are becoming more expensive and/or more restrictive, or that they may lose the benefit or the option of enrolling in an HMO altogether due to plan withdrawals. Once these beneficiaries return to original fee-for-service Medicare, it is almost impossible for them to purchase a supplemental policy that includes some prescription drug coverage due to cost and medical underwriting.

Fourth, beneficiary education about their Medicare options is critical to the success of the Medicare+Choice program. AARP supported Medicare+Choice in order to give beneficiaries the full benefit of innovations in health care delivery. However, Medicare+Choice can realize its potential only if beneficiaries acquire the knowledge that will enable them to exercise their leverage as informed consumers in the health care market place. We support the Health Care Financing Administration's (HCFA) efforts to educate beneficiaries, and AARP has joined with the Agency as a partner

in its education efforts. We believe Congress, too, must do its part by providing sufficient resources to enable HCFA to carry out its challenging tasks. In addition, we believe it is important that Congress not be overly prescriptive in defining HCFA's education initiatives, but rather allow HCFA the flexibility to employ a range of education techniques and materials for beneficiaries.

Issues Arising from Medicare+Choice Implementation

Medicare HMO Withdrawals and Benefit Reductions—Beginning late last fall, Medicare beneficiaries began to feel the effects of the program's transformation when over 400,000 beneficiaries found themselves displaced from their current HMOs after multiple plans terminated their Medicare contracts or reduced their service areas. This year again, more Medicare HMOs have announced that they would not renew their Medicare contracts or that they would reduce their service areas beginning in 2000. HCFA estimates that these changes will affect 327,000 beneficiaries.

AARP is deeply concerned about the dislocation these Medicare beneficiaries will face when their current HMO enrollment is terminated at the end of this year. All of these Medicare beneficiaries have the good fortune of still having Medicare coverage, but the departure of Medicare HMOs from their areas means they will have fewer choices for their Medicare coverage, and, in many cases, higher out-of-pocket costs.

The majority of affected beneficiaries have the option of joining another HMO in their area, but often this will mean changing doctors or losing extra benefits that had attracted them to a particular HMO in the first place. Beneficiaries are also entitled to return to original fee-for-service Medicare, but for many that is not a preferred option. Often, these beneficiaries chose managed care because it both relieved them of the financial burden of Medigap insurance payments and because it offered needed benefits, such as prescription drugs.

Under the BBA, beneficiaries who lose their HMO coverage and return to original Medicare are given certain rights to purchase—or repurchase—a Medigap policy. However, these beneficiaries will have to bear a the significant expense to do so, generally in excess of $100 a month. Even if they can afford Medigap, not all beneficiaries are protected by the rules. Disabled beneficiaries may not have the right to purchase any Medigap policy. With only very limited exceptions, older beneficiaries are not guaranteed the right to purchase a policy that includes drug coverage.

The 1999 Medicare HMO withdrawals will affect approximately five percent of all Medicare+Choice enrollees. While only a little over one percent of those currently in Medicare+Choice will lose the option to enroll in managed care entirely, the impact on each beneficiary affected is one hundred percent. In addition, the general disruption in the HMO market could make other beneficiaries reluctant to enroll in a Medicare HMO in the future.

Further, and probably of even greater impact next year, will be the number of Medicare HMOs that reduce their level of benefits and increase cost-sharing by beneficiaries. Many HMOs have announced that they will eliminate extra benefits such as prescription drugs and/or they will raise the premiums they will charge. Nearly three-fifths of plans are reporting they will cap prescription drug benefits below $1,000 next year. The proportion of plans with $5000 or lower drug caps will increase by 50% between 1998 and 2000. Further, beneficiaries who find themselves in this situation are at a serious disadvantage. Their HMOs may no longer include the benefits that made them attractive or their HMOs may now become much more expensive. Beneficiaries in this situation have limited remedies. They can try to find another HMO in their area or return to original Medicare, but they do not have the same protections for purchasing a Medigap policy as those whose HMOs actually have left the program, and even if they are able to find a policy, they will likely face considerably higher out-of-pocket costs.

Payment Methodology—Several reasons have been put forward to explain the HMO withdrawals from Medicare. The HMO industry contends that plans are pulling out of the Medicare market because the BBA Medicare payment rates and methodology are draconian. In contrast, the Government Accounting Office (GAO) has reported that the current movement of plans in and out of Medicare may be primarily the normal reaction of plans to market competition and conditions. In an April, 1999 report on Medicare managed care plans, GAO concluded that while BBA payment rates were undoubtedly considered by the plans in making their participation decisions, other factors involving the plans' ability to compete were associated with plan withdrawals. These included recent entry in the county, low enrollment, and higher levels of competition.

Whether or not the payments are adequate or fairly calculated is an issue that AARP cannot evaluate because we do not have enough data to do so. While it is tempting to blame the government for this turmoil, in actuality, competition in the managed care market place is playing a strong role. Aside from the federal payment, Medicare HMOs must consider whether they can compete effectively and attract enough Medicare patients to be profitable. If their bottom line performance is not strong enough in a given area, plans will adjust their benefits or pull out of the Medicare market entirely. This must be understood in order to determine how to preserve enrollment stability for beneficiaries without undermining the fiscal integrity of the program.

In this connection, Congress must continue to try to determine what the proper level of compensation for Medicare+Choice plans should be. To do this accurately will require more information about how much it actually costs a plan to operate efficiently and effectively. AARP has supported testing different payment approaches, including competitive pricing. We also have supported implementation of risk adjustment because we believe that it will lead to fairer plan compensation.

Ultimately, the HMO withdrawal situation and the expected benefit reductions underscore the importance of original Medicare. Regardless of the market decisions of private health plans, beneficiaries need the security of knowing original Medicare is there for them. It is not just those beneficiaries affected by HMO withdrawals that rely on original Medicare being there for them. A quick look at a map of the United States clearly illustrates that many areas of the country do not have HMOs, and many of these areas are not likely to see HMOs any time soon.

Greater Medicare Reforms

As we have noted, Medicare+Choice is still in its infancy and many of the changes enacted by the Balance Budget Act are still phasing in. The overall effects of these changes on beneficiaries, providers, and the Medicare program itself are not yet clear and there is much to be learned. The challenges and the successes of Medicare+Choice will have important implications for broader reform of the Medicare program. The amount of "fine-tuning" now under discussion for Medicare+Choice offers ample reason why larger-scale reforms in Medicare must be made slowly and cautiously.

While we have stated the importance of understanding the impact of the changes that have already been made before new changes are layered on top, this does not mean that the status quo in Medicare is acceptable. More must be done to ensure the program's long-term solvency and to modernize Medicare's benefits and delivery system.

To this end, AARP believes that the fundamental principles that have guided Medicare should continue to be the basis of any efforts to reform the program:

Defined Benefits Including Prescription Drugs—All Medicare beneficiaries are now guaranteed a defined set of health care benefits upon which they depend. A specified benefit package that is set in statute assures that Medicare remains a dependable source of health coverage over time. It is also an important benchmark upon which the adequacy of the government's contribution toward the cost of care can be measured. A benefit package set in statute reduces the potential for adverse selection by providing an appropriate basis for competition among the health plans participating in Medicare, and provides an element of certainty around which individuals, employers, and state Medicaid programs may plan.

When Medicare began, the benefit package was consistent with the standards for medical care at the time. In any reform, it will be important that the benefits be clearly defined and reflect modern medical practices. To this end, prescription drugs must become part of the standard Medicare benefit package and can be available to all beneficiaries in whatever plan they choose.

Adequate Government Contribution Toward the Cost of the Benefit Package—It is essential that the government's contribution or payment for the Medicare benefit package keep pace over time with the cost of the benefits. Currently, payment for traditional Medicare is roughly tied to the cost of the benefit package. If the government's contribution were tied to an artificial budget target and not connected to the benefit package, there would be a serious risk that both the benefits and government payment would diminish over time. In addition, a change that results in a flat government payment—regardless of the cost of a plan premium—could yield sharp out-of-pocket premium differences, both year-to-year and among plans, with resulting volatility in enrollments.

Out-of-Pocket Protection—Changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket costs. The average Medicare beneficiary spends nearly 20 percent of his or her income out-of-pocket for health care expenses, excluding the costs of long-term care. In addition to items and serv-

ices not covered by Medicare, beneficiaries have significant Medicare cost-sharing obligations: a $100 annual Part B deductible, a $768 Part A hospital deductible, 20 percent coinsurance for most Part B services, a substantially higher coinsurance for hospital outpatient services and mental health care, and a significant coinsurance for skilled nursing facility care. Currently, there is no coinsurance for Medicare home health care.

Beneficiaries already pay a substantial amount of their health care costs—from services not covered by Medicare, to Medicare's cost-sharing obligations, to their $45.50 monthly Part B premium. Further, the Part B premium beneficiaries pay is expected to almost double in the next ten years.

AARP believes that beneficiaries are now paying, and should continue to pay their fair share for Medicare. However, if their cost-sharing became to high, Medicare beneficiaries would face increasingly unaffordable barriers to appropriate and necessary services. In addition, if cost-sharing varies too greatly across plans, the potential for greater risk selection would increase, leaving many beneficiaries with coverage options they might consider inadequate or unsatisfactory.

Protecting the Availability and Affordability of Medicare Coverage—Medicare should continue to be available to all older and disabled Americans regardless of their health status or income. Our nation's commitment to a system in which Americans contribute to the program through payroll taxes during their working years and then are entitled to receive the benefits they have earned, is the linchpin of public support for Medicare. Denying Medicare coverage to individuals based on income threatens this support. Furthermore, raising the age of Medicare eligibility would have the likely affect of leaving more Americans uninsured. Thus, in the absence of changes that would protect access to affordable coverage, raising the eligibility age for Medicare is unacceptable to AARP.

Administration of Medicare—Effective administration of the program remains essential. The agency or organization that oversees Medicare must be accountable to Congress and beneficiaries for assuring access, affordability, adequacy of coverage, quality of care, and choice. It must have the tools and the flexibility it needs to improve the program—such as the ability to try new options like competitive bidding or expanding centers of excellence. It must ensure that a level playing field exists across all options; modernize original Medicare fee-for-service so that it remains a viable option for beneficiaries; ensure that all health plans meet rigorous standards; and continue to rigorously attack waste, fraud and abuse in the program.

Financing—Medicare must have a stable source of financing that keeps pace with enrollment and the costs of the program. Ultimately, any financing source will need to be both broadly based and progressive. Additionally, AARP supports using an appropriate portion of the on-budget surplus to insure Medicare's financial health beyond 2015.

Conclusion—The initial implementation of Medicare+Choice is teaching us some valuable lessons. It is essential that changes from the BBA and their impact on current and future beneficiaries are thoroughly analyzed before greater changes take place. AARP looks forward to continuing to work with the Commerce Committee and your colleagues in the House and Senate to improve upon the Medicare+Choice program. We also want to work with you to advance a Medicare reform package that includes prescription drug coverage. The status quo in Medicare is not acceptable, but together we must ensure that any reform package continues Medicare's promise of quality, affordable health care.

Mr. BILIRAKIS. Thank you, Ms. Canja.

I was remiss in not congratulating you and also welcoming you.

Ms. CANJA. Thank you. It's good to see you.

Mr. BILIRAKIS. It's hot down there in Florida. It is good to be up here.

Ms. CANJA. Yes.

Mr. BILIRAKIS. Dr. Moon?

STATEMENT OF MARILYN MOON

Ms. MOON. Thank you. I appreciate the opportunity, Mr. Chairman, to be here today to discuss the issues surrounding how private managed care plans are operating under Medicare.

There is, as we've heard today, a great deal of flux in the market that is out there, but not all of it, I believe, is due to the Balanced

Budget Act. Some of it is due to the natural workings of a marketplace, and it is important to sort those out.

As an important option for beneficiaries, the Medicare program should, indeed, foster and encourage private plans to participate. But, in turn, private plans need to be held accountable to the goals that these plans are intended to achieve. That is, to achieve savings through the advantages of care management for the Federal Government and beneficiaries, to allow beneficiaries who like this kind of an environment the opportunity to have the opportunity to receive their care from such a plan, and to encourage plans to offer innovative services and benefits. That's the promise, and hopefully the delivery, that will happen in terms of having a managed care option or private plan option in the Medicare program.

A look back over time indicates that Medicare's payments were not only generous in the past, they were often substantially higher than what was being received by plans treating other population groups.

At the same time that private managed care plans were arguing that they are more efficient than fee-for-service and offering their services with low annual growth rates for the under-65 people, they were getting the fee-for-service growth rate increases in Medicare, often in excess of 10 percent a year, handed to them each year.

The changes enacted in the BBA all have strong justifications in past research and analysis and should not necessarily be thought of as a fairness gap; rather, they are an attempt, I believe, to level the playing field between private plans and Medicare, which for some time has been tilted in favor of private plans.

Plans do have legitimate claims to fair treatment in terms of payment levels, stability over time in those payments, and requirements on their behavior, but simply because plans are pulling out or reducing their benefits does not necessarily say that the changes in the BBA were wrong.

For preliminary information available on what will happen in January, 2000, it appears that the share of beneficiaries affected at all will be less than 1 percent of the Medicare population. This is certainly comparable to the share of persons expected to be affected by the Federal employee's health benefits program, for example, and the pullouts that will occur there next year, and just half the share of retirees in FEHBP who normally change plans each year.

In a market system, withdrawals should be expected. Indeed, they are a natural part of the process by which uncompetitive plans that cannot attract enough enrollees leave particular markets. Certainly, last year many of the pullouts that occurred where the enrollees were in areas where there were 5,000 or fewer beneficiaries indicate that there are certainly issues going on in the flux in the market that is, to some extent, a natural process.

The whole idea of competition is that some plans will do well and in the process drive others out of those areas. In fact, if no plans ever left, that would likely be a sign that competition was not working well. So if we want to have a competitive market environment we're going to have to expect these kinds of withdrawals.

That's not to say it is necessarily easy or pleasant for the beneficiaries that are involved in this kind of situation, but some have suggested also that the scaling back of extra benefits signals that

payments are too low for these plans. However, to the extent that extra benefits were made possible by overly generous premium payments from Medicare, as we've heard earlier today, these changes may again be viewed as leveling the playing field.

Although it is painful for beneficiaries attracted to these private plans for promised extra benefits to lose them in the next year, a greater injustice would be done by increasing payments to assure that private plan enrollees get extra benefits, while those who remain in fee-for-service, either by choice or by necessity, do not.

While withdrawal of plans is both a natural and necessary part of a competitive, market-based approach, that does also not mean that the transitions will be smooth or painless or that we should ignore them.

For those who are in poor health, for those in the middle of a treatment regimen for a problem like cancer, for those who are frail or home-bound, having to make major changes in their personal health care delivery system will, indeed, be very difficult, and it is important to find ways to assure that there is as much stability in the system as possible, but I don't think we just jump to higher payments to do that.

I believe we need to have a lot better education for individuals so that they understand what the implications are of a market system, and I also believe that prescription drugs are a particularly key benefit, because it is one that is easy to manipulate and one for which people are both attracted and at great risk when changes occur.

Thank you.

[The prepared statement of Marilyn Moon follows:]

PREPARED STATEMENT OF MARILYN MOON, SENIOR FELLOW, THE URBAN INSTITUTE

I appreciate the opportunity to be here today to discuss issues surrounding how private managed care plans are operating under Medicare. The flux in the overall health care market and changes brought about by the Balanced Budget Act of 1997 have generated challenges for the private plans that serve Medicare. It is important to attempt to sort out what is happening, why and whether it generates problems for the beneficiaries that the program was designed to serve.

Although private plan options have been around for quite a long time, they have recently begun to attract a larger share of the Medicare population. This makes them an ever more important feature of Medicare. Moreover, since many of the options for reforming Medicare now being discussed would either place more reliance on such plans and/or change the way in which they operate within Medicare, there may also be important lessons for reform from studying what is happening today.

The headline in a recent press release from the American Association of Health Plans proclaimed, "Insufficient Government Funding for Beneficiaries Forces Medicare HMO Cutbacks." My testimony today will contend that announced withdrawals are not particularly surprising or unusually large, that the reason offered by AAHP for such changes is only one of several possible explanations for changes occurring in private plans, and that the real issue is what will happen to Medicare beneficiaries as a result of these changes. But first, it is important to examine some background on what has been happening to Medicare + Choice.

The Role of Private Plans in Medicare

As an important option for beneficiaries, the Medicare program should foster and encourage private plans to participate. But, in turn, private plans need to be held accountable to the goals they are intended to achieve: 1) to use the advantages of care management to achieve savings for the federal government and beneficiaries, 2) to allow beneficiaries who like a managed care environment the opportunity to receive their care from such a plan, and 3) to encourage plans to offer innovative services and benefits. If these plans cannot do better than the basic Medicare program in restraining costs and if they do not generate "value added" in terms of pro-

viding alternatives that attract beneficiaries, then should alarms be raised if this option does do not become a greater share of the Medicare program?

The BBA sought to both offer additional alternatives to beneficiaries and to achieve savings from private plans through various payment reforms. Even more than many of the savings achieved from the traditional fee-for-service part of the program, the BBA changes in payment reflected a strong body of research that had demonstrated that payments to private plans were too high on average. Medicare was losing money on each beneficiary who signed up for this option. This was because beneficiaries opting for managed care were (and according to a recent study by the General Accounting Office, still are) healthier than others like them in the beneficiary population. The existing risk adjustment mechanism failed to capture these differences. Consequently, Medicare paid too much for each enrollee, enabling plans to use these resources to offer additional benefits that made them attractive to potential enrollees. Further, the Medicare program contains a number of additional subsidies for certain hospitals in its fee-for-service payments to help support medical education and coverage of indigent patients. Because of the way in which premium payments to private, managed care plans were made prior to BBA, these subsidies were passed on to the plans. But plans were not required to then pass on these benefits to the hospitals who should be receiving such subsidies. Consequently, payments were too high for this reason as well.

A look back over time indicates that Medicare's payments were not only generous, they were often substantially higher than what was being received by plans treating other population groups. At the same time that private managed care plans were arguing that they were more efficient than fee-for-service and were offering their services with low annual growth rates, they were getting the fee-for-service growth rate increases (often in excess of 10 percent) handed to them each year in Medicare.

The BBA attempted to rectify these issues with three sets of changes: 1) addition of an improved risk adjustment mechanism beginning next year, 2) short term reductions in payment levels to bring the amounts closer to where they should have been if a better risk adjustment factor had been in place in the past, and 3) taking out of the premium payments for private plans part of the cross-subsidies found in Medicare and instead giving them directly to hospitals. These changes all have strong justifications and should not be thought of as a "fairness gap." Rather, they are an attempt to level the playing field between private plans and Medicare which for some time has been tilted *in favor of* private plans. Further, if these changes had been fully applied, some plans might actually have seen their payments decline; but the BBA placed a safety valve of a guaranteed 2 percent increase in payments each year even for plans in very high premium areas.

Plans do have legitimate claims to fair treatment in terms of payment levels, stability over time in payments and requirements on their behavior. Reporting rules and regulations should be reasonable in terms of the costs of complying. And it is important to continue to monitor payment levels to assure that they are fair. But just because the payment levels have been restricted is no reason to believe there is a problem. It is necessary to look further.

To demonstrate that they are being unfairly treated, plans have been pointing to the withdrawals and lower benefit offerings that occurred in 1999 and that have been announced for January 1, 2000. But here again, it is necessary to ask whether this is just due to Medicare payment changes and new regulations or whether other factors are also at work.

Putting the Size of Withdrawals into Context

A large number of plans announced withdrawals from Medicare + Choice in 1999. But by June of this year, the number of total participants in the program was 6.86 million beneficiaries, up over 260,000 persons from June of 1998 (when the figure was 6.40 million). Further, the number of risk contracts, while smaller, was still over 400.

From preliminary information available on what will happen in January, 2000 to plans participating in Medicare + Choice, it appears that most beneficiaries will be unaffected. That is, 95 percent of enrollees in these plans will not have to make changes unless they elect to shift. Since enrollees in Medicare + Choice accounted for a little over 17 percent of all Medicare beneficiaries, the share of beneficiaries affected at all will be less than 1 percent. That is comparable to the share of persons expected to be affected by the Federal Employees Health Benefits Program (FEHBP) pullouts next year and just half the share of retirees in FEHBP who normally change plans each year, for example. Further, over three-fourths of those beneficiaries affected by withdrawals will still have at least one other private plan to choose from in addition to traditional Medicare. As this suggests, one major reason

why individuals may have to change plans has more to do with the nature of a private-sector approach to Medicare.

What Are the Implications of Private Plans and Competition in Medicare?

Choice among competing plans and the discipline that such competition can bring to prices and innovation are often stressed as potential advantages of relying on private plans for serving the Medicare population. But imbedded in those characteristics are also some of the responses by plans that are now being heavily criticized. That is, if there is to be choice and competition, some plans will not do well in a market and as a result they will leave. In a market system, withdrawals should be expected; indeed, they are a natural part of the process by which uncompetitive plans that cannot attract enough enrollees leave particular markets. If HMOs have a hard time working with doctors, hospitals and other providers in an area, they may decide that this is not a good market. And if they cannot attract enough enrollees to justify their overhead and administrative expenses, they will also leave an area. The whole idea of competition is that some plans will do well—and in the process drive others out of those areas. In fact, if no plans ever left, that would likely be a sign that competition was not working well.

No one has raised major objections to the fact that a share of FEHBP plans drop out of that program each year, for example, or that individuals shift across plans. It seems inconceivable then to criticize the Medicare program simply because some plans leave various markets. That is the very nature of competition. And, from preliminary data, it appears that many of the withdrawals by plans are only in certain areas where the affected plans were unable to reach a critical mass to continue in operation. This was also a key reason for withdrawals in January of 1999.

The Issue of Premium Increases and Benefit Reductions in Medicare + Choice

Most plans routinely eliminate or reduce Medicare's cost sharing requirements and add other benefits as well. Because managed care plans seek to oversee the use of care directly rather than relying as much on cost sharing as compared to fee-for-service plans, managed care organizations do not need to be compensated for this additional offering; indeed, beneficiaries should expect this as a tradeoff for having less autonomy in the care they receive. But in addition, many managed care organizations also offer extra benefits such as prescription drug coverage, dental and vision care at either no additional premium or a premium substantially below the costs of private medigap coverage that many fee-for-service patients purchase.

The announcement by some plans who are remaining in Medicare that next year premiums will be increased or extra benefits cut is likely related to Medicare policy changes (as well as to other factors such as the increasing costs of prescription drugs). Because premium payment levels by the federal government are not increased as fast as in the past, it should not be surprising that plans respond by restricting the generosity of the additional benefits they offer beyond what Medicare requires.

But some have suggested that the scaling back of extra benefits signals that payments are too low for these plans. However, to the extent that these extra benefits were made possible by overly-generous premium payments from Medicare, these changes again may be viewed as leveling the playing field. Beneficiaries who do not or cannot enroll in private plans have been at a disadvantage because they do not have access to these extra benefits. If payments to plans were raised to restore extra benefits, this would thus generate a critical fairness issue. Although it is painful for beneficiaries attracted to these private plans for promised extra benefits to lose them in the next year, a greater injustice would be done by increasing payments to assure that private plan enrollees get extra benefits, while those who remain in fee-for-service do not.

Beneficiaries at Risk

While a strong case can be made that many of the changes affecting Medicare's private plans are a combination of market forces and intended policy changes that require no intervention by the Congress, there will be important and painful impacts on beneficiaries. And these consequences should be carefully examined for lessons for the future.

While I have argued above that it is important to recognize that withdrawal of plans is both a natural and necessary part of a competitive, market-based approach to providing health care, that does not mean that transitions will be smooth or painless for beneficiaries. For those in poor health, for those in the middle of a treatment regimen for a problem like cancer, for those who are frail or homebound, having to make major changes in their personal health care delivery system will be difficult. Finding ways to assure that there is as much stability in the system as possible

for these beneficiaries is crucial, and somewhat at odds with a market-based approach.

Even if the benefits that individuals have enjoyed in private plans came about because of overly generous federal contributions, that will not make beneficiaries content to lose such benefits over time. Many older and disabled persons have been attracted to managed care plans precisely because of the extra benefits offered. They may have made sacrifices to join such plans, including learning a new system of care and finding new doctors and other service providers only to discover that next year these benefits will be scaled back. How many beneficiaries understand that once they join a plan with all its promised benefits, that the promise extends for only one year?

Remedies that sustain these windfall benefits are not fair to other beneficiaries who remain in fee for service. Instead, better education and information on the issue of what it means to enroll in a private plan option is needed. Recent surveys have shown that many beneficiaries do not understand the full range of conditions and requirements surrounding managed care, suggesting that they may be attracted by extra benefits and other promises without understanding the full nature of that decision. Advertising for such plans, for example, has a tendency to tout in headlines the extra benefits but use the small print to caution about restrictions. Managed care plans can have a lot to offer Medicare beneficiaries, but the choice should be an informed one.

Another key issue raised by the changes announced by plans this year, and a trend that has actually been going on for several years, is the nature of the cutbacks in benefits. Many analysts have noted and warned that prescription drugs are difficult to offer in a fully voluntary environment because they naturally attract a sicker population who are likely to be heavier users of health care of all sorts. It is thus natural for plans looking for ways to reduce their costs to cut back on such benefits. If these benefits are increasingly limited over time, it will increase the importance of the debate over whether drugs ought to be offered as part of a basic Medicare package.

Mr. BILIRAKIS. Thank you so much.

Rabbi Malavsky?

STATEMENT OF RABBI MORTON MALAVSKY

Rabbi MALAVSKY. Thank you very much. Good morning, Chairman Bilirakis, Ranking Member Brown, and other distinguished members of the Health Subcommittee. Or, Chairman Bilirakis, should I say good morning? Or, no, it is already afternoon.

Mr. BILIRAKIS. You do it well.

Rabbi MALAVSKY. I am Rabbi Morton Malavsky, and I am pleased to be here this morning to talk to you in person about some of my experiences with the Medicare+Choice program, particularly Humana's health plan, its services, and its doctors.

You know, I feel I must digress a little bit and draw this analogy. Science has progressed so much today, when you want to call some firm or outfit you dial the telephone and it is push one, push two, push three, push five. It's annoying. You sit there for the longest time and you're pushing all kinds of buttons. When I do that and somebody finally comes on, I say, "Thank God there is a live person there that I can talk to." Well, I'm that live person who is here today to talk to you as one of the beneficiaries that you are all talking about but so few people get to meet or to see.

I know that there have been pros and cons about the program, but would somebody tell me of any program that they know, be it in the health field or otherwise, that there is no controversy about? Any program?

As a matter of fact, in my years of experience I have found that the better a program, the more controversy, the more people look to find problems with it.

I am here today to tell you that I am one of the 6 million and more, and the overwhelming majority of HMO members who are very happy with their plan, and I would very much appreciate for Congress not to do anything that would jeopardize what we already have.

Moreover, I would beg that they live up to the commitment to the Medicare+Choice program by ensuring its viability financially in the future.

Of course we are grateful. We are grateful to Chairman Bilirakis and to Congressman Deutsch for your outstanding work in introducing H.R. 2419. It does provide seniors the confidence that our Medicare+Choice program is here to stay in our communities.

First of all, let me tell you that I quite regularly proudly tell my friends that I am enrolled in an HMO. I haven't had problems yet. In fact, I deal with people who have problems in their traditional programs, dealing with bureaucracy and other situations.

I have been a member of Humana HMO for the past 5 years. Initially, I joined Humana because my doctor, who was then my primary physician, recommended I do so and suggested that I would benefit from the type of coordinated care, from the preventative to the acute services——

Mr. BILIRAKIS. Rabbi, forgive me, sir, but we have a vote on the floor, and we're probably down to about 2 minutes. I don't want you to have to rush through. You're on a roll here.

Anyhow, I think it is best if, with your forgiveness, we break at this point.

Rabbi MALAVSKY. Fine.

Mr. BILIRAKIS. Because we've got to run, and I know that a lot of people probably want to grab a bite to eat, let's break until 1:20. That will give you all an opportunity to grab a quick bite, too.

Rabbi, we'll get right back to it, so hold that thought.

[Brief recess.]

Mr. BILIRAKIS. Now, Rabbi, for the sake of continuity, you're welcome to back up in your testimony and not necessarily start from the beginning, but virtually so.

Rabbi MALAVSKY. All right.

I left off just past where I said that I regularly am proudly happy to tell my friends that I am enrolled in an HMO and that I've never had problems.

In fact, it is the people with traditional programs that I see on a regular basis lying there and waiting in the emergency rooms, waiting for service, and others trying to get appointments with doctors and waiting lists, etc., etc.

I have been a member of Humana HMO for 5 years, since 1994. Initially, I joined Humana because my physician, who had been my physician at that point for about 24 years, suggested, and he said I would benefit from the type of coordinated care, from preventative to acute services, as well as prescription drug coverage.

Congress, I hope, will adequately fund the Medicare+Choice program. If not, there are many, many thousands of seniors and millions of them like me who will have no choice and no access to these type of services.

Every day, Medicare+Choice is making a positive difference in the health of seniors and their lives.

Let me take but a few moments and tell you a little bit about the experiences I've had, just one or two, in utilizing—unfortunately and fortunately—some of the medical assistance and experiences that I have gone through.

It is regularly commented upon that an ounce of prevention is worth a pound of cure. My physician would regularly say to me, "You know, your plan or your Medicare or your supplemental insurance will not cover procedure A, B, or C, but I think we ought to do it anyhow." He was more than my primary, he was my friend, and so it was done.

When I came under the plan, there was no question about it. And this happened twice, once about 4 years ago and then this summer again. My prostatic screening was irregular, and the PSA had gone to two or three times the number. I've learned all about it, since. And both the physician and the urologist immediately thought of one thing—cancer. They needed to go beyond that, and going beyond that meant a test, it meant a biopsy.

Well, the test was taken and the biopsy was taken and, had I been not under HMO but a supplemental insurance or Medicare that I used to have, first, they would not have required it, and if I had done it and it came up as it did, there would have been quite a bit out-of-pocket expense.

The results, by the way, were startling because it was shocking to both of my physicians, and when they sent me to the work-up and the biopsy, thank God—I had to wait for a full week, but it came through. My urologist has given me a clean bill of health, with the only thing that I need to go back every 6 or 8 months or something to check it out.

Preventative services I honestly believe saves lives and saves your mind thinking about it. You can just go to pieces worrying about what might happen, and I'm thankful that my health plan places such importance on preventative medicine, on checking these things out.

But, you know, the health plan is there not only for preventative services; they are there when you need them in an emergency, as well.

It will be 2 years this Yom Kippur that I very sadly think back, and yet I am very grateful. After the memorial service in the afternoon, I suddenly felt ill on the pulpit. I broke out in cold sweat. I had a physician who is not mine, but there are several physicians in the congregation all the time—they do come to services—and I motioned to one of them. He came up and he was very conservative about his approach. He's not my doctor and did not know my case, but took me right back, had me lie down on the floor, called the 9-1-1 and had the full spiel, everything.

In the meantime, they reached my doctor. He gave them a diagnosis over the phone of what he thought it might be, but they would take no chances.

I was rushed to a hospital Yom Kippur afternoon. There was a team of doctors and nurses waiting for me.

I am an HMO patient. I am not a supplemental or just Medicare or top-paying patient. They were waiting for me—didn't take any time getting information. They already had it.

I was tired of what they did to me with the tests and testing and checking. I don't think they left a drop of any stone unturned. And then they had a list of things that I had to do—this test, that test. I was hospitalized for 3 or 4 days. My physician came up right away. His diagnosis happened to be so. It was hypoglycemia. It was not the heart. But I had a stress test and I had a vascular surgeon and a neurological surgeon—all of them, people I've never heard of, problems I've never had before, but everything was checked out.

And when I left, and even after that, I said, "Is there any bill?" "No, no, it's all taken care of. Everything is taken care of. All you have to do is go back to these different doctors from time to time."

Mr. BILIRAKIS. Please summarize, Rabbi, if you will.

Rabbi MALAVSKY. Yes.

With a track record like this, it's not surprising that my health plan has been recognized for their congestive heart disease management program. This program has given so many people additional life.

And medication—I probably save close to $5,000 a year. I don't know about the dollars and cents, but I would welcome you to compare what HMO gets and what Medicare gets. I think you'll find that some of the traditional Medicare payments and fee-for-service payments are considerably higher.

So let me say to you we beg of you to see to it. You've allowed us to grow older. We, the senior citizens of America, owe you, the Congress, a great debt. You have developed medicine scientifically to a point that, whereas people were dying in the 60's and 70's, it is now 80's and 90's, it will be 100's and 110's and 120. But now that we grew older, help us stay well.

I cannot think of anything better to describe that but a little analogy. It's a little European story that I finish with, a story where we are told that the Congress is ready to take this away and that away and give us less and less; that a man who was a taxi driver in a small town in eastern Europe, he was—not a taxi, he had a little wagon and a horse and he would take people from town to town. He couldn't make it. It was rough. So he decided he's got to cut expenses, so he fed his horse a little less 1 day. You know what? He still carried the load the next day, so he gave him a little less yet, and again a little less.

On the sixth day the horse died. So he came to his rabbi and he said, "I don't understand. I finally taught my horse not to eat and he died on me."

You have brought us to a station in life that we never dreamed of. We're up there in years, the 70's and 80's and 90's. Please don't neglect us, whatever it takes, however you work it out. Don't fix it if it's not broken, and don't deny us this wonderful, wonderful service.

Thank you very much.

[The prepared statement of Rabbi Morton Malavsky follows:]

PREPARED STATEMENT OF RABBI MORTON MALAVSKY

Introduction

Good morning, Chairman Bilirakis, Ranking Member Brown, and other distinguished members of the Health Subcommittee, I am Rabbi Morton Malavsky and I am pleased to be here this morning to talk to you about my experience with the

Medicare+Choice program and, particularly, my experience with my Humana's health plan and doctors.

I know HMO quality has been a big issue. I am here today to tell you I am one of an overwhelming majority of HMO members who is extremely pleased with my plan. And, I don't want Congress to do anything that will put my benefits in jeopardy. Moreover, I want the Congress to live up to its commitment to the Medicare+Choice program by ensuring it remains financially viable. Thank you, Chairman Bilirakis and Congressman Deutsch, for your outstanding work in introducing H.R. 2419—it does provide seniors the confidence that our Medicare+Choice program will stay in our communities.

First of all, let me say, I regularly and proudly tell my friends I am enrolled in an HMO. I have *never* had problems. In fact, it is my friends in the traditional Medicare program, dealing with the government bureaucracy, who seem to have the problems.

I have been a Humana member since 1994. Initially, I joined Humana because my doctor recommended I do so and suggested that I would benefit from the type of coordinated care—from preventive to acute services, as well as prescription drug coverage—that Humana offers. Congress needs to adequately fund the Medicare+Choice program—otherwise thousands of seniors, like me, will have no choice and no access to these types of services.

Every day, Medicare+Choice is making a positive difference in seniors' health and lives. And, I want to take a few moments to share with the Committee members some of my personal experiences.

Preventive Services

You always hear that an ounce of prevention is worth a pound of cure. Early this summer, I underwent a prostate screening assessment (PSA). My Humana health plan insisted I get this test I may not have on my own. The supplemental insurance I used to have would not have covered this.

Well, the test results were startling. I was shocked when my doctor indicated that there was a possibility of cancer because my PSA had risen dramatically. My doctor then sent me immediately to an urologist for a work-up and a biopsy. I thank God the results were negative.

My urologist has since given me a clean bill of health and made a point to establishing a schedule for my routine check-ups. Preventive services do save lives and I am thankful that my health plan places such importance on these early detection services.

Acute needs

But my health plan isn't just there for preventative services; they were there when I needed them most. In 1997, while at the pulpit delivering a sermon during Yom Kippur, I broke into a cold sweat and began to experience chest pains. Within minutes, a physician in the congregation came to my aide. I was raced to an emergency room where my own personal doctor met me. While my doctor thought I probably hypoglycemia, he thought it was important for me to get immediate attention anyway. At the hospital emergency room, there were a team of physicians and nurses to treat me. I underwent a myriad of tests, including a stress test. No stone was left unturned. The quality of care that I received in the emergency room was first-rate. And, Humana paid the entire bill. Under my old supplemental plan, I would have had to pay a deductible and coinsurance—even for this emergency care.

With a track record like this, it is not surprising that my health plan has been recognize for their congestive heart disease management program. Seniors like Humana and their team of doctors because, like me, they are confident that the quality of care will be the best the system has to deliver.

Prescription Drugs Coverage

Medicare+Choice plans give seniors affordable access to life-enhancing prescription drugs. More importantly, Medicare+Choice plans help protect seniors from catastrophic health care costs of escalating drug costs. Prior to joining Humana 1994, I was paying a monthly Medigap premium of over a $125 a month and averaged monthly out-of pocket costs of $200 per month in out-of-pocket expenses. To seniors, this is real money. For me specifically, I save about $5000 per year. No press release or political speech can ease the anxiety seniors' feel when they are faced with the uncertainty rising prescription drug costs or the potential of losing their drug benefit. In Lakeland, Florida, Humana is able to offer prescription drug coverage with a $10 co-payment. It is not difficult to understand that I was attracted to a Medicare+Choice option because of two simple factors—lower costs and better benefits.

Conclusion

In closing, I would like to share a story with you. There was a man who thought he'd save money on his deliveries if he could just save money on the grain it took to feed his horse. So, he decreased the amount he fed his horse. Well, he was so impressed with the money he'd saved, he fed the horse even less. Finally, he thought he could save a lot more money if he didn't feed the horse at all. As you can guess, the horse died from starvation.

My point is this: Medicare+Choice is a program that works. Please do not be shortsighted and starve it. You could kill the program—a program that provides quality benefits (which for me include prescription drugs, eyeglasses, and hearing aids) to a large number of seniors who rely on it and believe it is a real choice.

Again, thank you for the opportunity to appear before you to share my experiences with the Medicare+Choice program. I would be pleased to answer any questions the Committee members have.

Mr. BILIRAKIS. Thank you very much, Rabbi.

Mr. BURR. Mr. Chairman, clearly HCFA has heard his story before about the horse.

Mr. BILIRAKIS. Rabbi, you are, of course, a rabbi and a leading citizen of the community area, so I would ask you, the treatment that you received, is that also available, in your opinion, to others, based on your personal knowledge?

Rabbi MALAVSKY. Yes. I was just one of the patients. They didn't even know who I was.

Mr. BILIRAKIS. They didn't even know who you were?

Rabbi MALAVSKY. No. It wasn't until a day later that they were sort of embarrassed. Did we do all right? Did we take care of you?

Mr. BILIRAKIS. Thank you.

Ms. Canja, in your testimony AARP supported the—and I'm quoting—"creating of Medicare+Choice in order to accomplish the objective of expanding choice."

Well, now is there an AARP position regarding HCFA's interpretation of BBA 1997 where they have basically taken, or are contemplating taking $11.2 billion based on their figures, out of the reimbursement picture on Medicare+Choice?

Ms. CANJA. We do support it.

Mr. BILIRAKIS. You support?

Ms. CANJA. We support it because we——

Mr. BILIRAKIS. You support taking the dollars out?

Ms. CANJA. I can't respond to that part, but we watched what they were doing, we observed what they were doing, and felt that it was appropriate, felt that risk adjustment was very appropriate, and felt that they really did try to meet the concerns of all parties. So, on that basis, we did support it. We will look carefully at your concerns and at Congress' concerns.

Mr. BILIRAKIS. Well, we're concerned, of course, that some people don't have that choice that AARP feels so strongly about; I think all of us feel strongly about choice, in general.

Are there ways to address and take a look at the risk adjustment picture and whether or not the way that HCFA is going about it is the right way and that sort of thing? I suppose there are, but in the meantime you've got an awful lot of people—10,000 in Florida, Ohio and we can go on and on, that are really basically without choice.

And so I would hope that you would—to use Mr. Brown's term—deal with the situation at hand, and that is basically people out there without a choice.

Ms. CANJA. Our staff is here and has met with your staff, and I know that they will be very happy to work with you on that.

Mr. BILIRAKIS. Great. We'd appreciate that.

Ms. Ignagni, taking a look at the July 1 information we received regarding the HMOs dropping from Medicare.

Ms. IGNAGNI. Yes.

Mr. BILIRAKIS. In Florida, one of them is Florida Health Choice, Inc., in the county of Broward, 256,000-plus Medicare beneficiaries, 121,000 Medicare-plus enrollees. The number of affected enrollees as a result of their dropping out is 1,659. Their 1999 rate was $676.64, due to go up—I guess there's a 2 percent growth—to $690.17.

Why would they, considering all that, drop out?

Ms. IGNAGNI. It is hard to answer in real terms on the particular organization you describe and what the dynamic was in that market, but, in general, what we have found in talking with our plans around the country is that many plans that are now in relatively higher payment areas are feeling the crunch of many of the aspects of the Balanced Budget Act formula working together, so that the effect was, I believe, when you enacted BBA 1997, you didn't anticipate all of the interactions—no one could have at that time—that are going on now.

So, for plans that are facing fairly high rates of increase, when the traditional program this year, for example, is at 5.8, and you're down less than 2, because with risk adjustor and the user fee taking out in that county it would be less than 2, then plans are finding it is very hard to contract with providers.

Mr. BILIRAKIS. We're trying to work on that subject, as you know.

Ms. IGNAGNI. Yes.

Mr. BILIRAKIS. And your people have been cooperative with us. As Ms. Canja has said, we've met with the AARP people, etc.

Ms. IGNAGNI. Yes.

Mr. BILIRAKIS. So we are trying to solve that problem. I received a 2- or 3- or 4-page letter from Blue Cross/Blue Shield, for instance—I don't even know if they are in the audience—but they basically said, "Look, we have the same problems but we're going to stay in—" in Florida, at least.

Ms. IGNAGNI. Yes.

Mr. BILIRAKIS. I'm not really sure. I don't have the letter right here, but I don't remember whether it was just in Florida or overall. And they're willing to give us the benefit of the doubt rather than hurt beneficiaries or put them in fear and that sort of thing.

I'm very disappointed. I mean, you know that. We've talked about it before.

Ms. IGNAGNI. Yes. And in many cases it depends on your contractual relationships with physicians and with hospitals whether or not——

Mr. BILIRAKIS. Well, I was going to get into that. I think it was you who testified to that effect about providers.

Ms. IGNAGNI. Yes.

Mr. BILIRAKIS. Some of the problems, may be that a lot of providers are just not wishing to continue because of the——

Ms. IGNAGNI. But they have legitimate concerns, so this isn't a case where the health plan arena is saying——

Mr. BILIRAKIS. Well, my son is a physician, and he doesn't talk very much to me, frankly, about any of these problems, but I can sort of see it.

Ms. IGNAGNI. Yes. I think that what physicians are telling us is that when they look at the sum total of what they are being asked to do under this program relative to fee-for-service, given the financial situation, the decline in payments, and the increase in administrative obligations that's pushed down from HCFA to health plans to physicians and hospitals, that in many cases they don't feel that it is worth their while any more, which really does affect choice. It affects the entire market.

And this is not a situation that I think we can ignore. It is not just the health plans. We're hearing this daily as we go around the country from physicians and hospitals.

I think they are right. I think these issues are very legitimate.

Mr. BILIRAKIS. Yes, they are.

Now, those notebooks consist of, what, approximately 800 pages, or more, the regulations?

Ms. IGNAGNI. Yes. The first reg, then there was a mini reg, and there have been operation policy letters. There have been 42 all told, so it is almost one every week, and they are about 30 pages each. So plans are reeling from the impact administratively, and that is all pushed down to the contract level, at the provider level, at the hospital level.

So what people are saying is not that we don't want to participate in a system that is accountable, but let's look across the spectrum and begin to think about proportional accountability and fee-for-service as well as managed care, which has driven down the regulatory impact on one side, only one side.

And HCFA keeps saying that they're going to get to it on the other side, but meanwhile the providers are saying that just doesn't make sense, looking at the burden and the obligation.

Mr. BILIRAKIS. All right. Thank you. My time has certain expired.

Mr. Brown?

Mr. BROWN. Thanks, Mr. Chairman.

I was hoping those notebooks would have been cost data that we have been asking you all for.

First, Mr. Chairman, if I could, I'd like to enter into the record GAO study, June, 1999, Medicare+Choice Reforms Have Reduced but Likely Not Eliminated——

Mr. BILIRAKIS. Without objection.

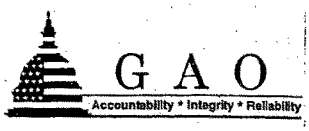
[The information referred to follows:]

United States General Accounting Office
GAO
Report to Congressional Requesters

June 1999

MEDICARE+CHOICE

Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments



GAO/HEHS-99-144

Printed copies of this document will be available shortly.

B-282937

June 18, 1999

The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

The Honorable Fortney (Pete) Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Balanced Budget Act of 1997 (BBA) created the Medicare+Choice program to expand beneficiaries' health plan options, both by encouraging the wider availability of health maintenance organizations (HMO) and by permitting other types of health plans, such as preferred provider organizations, to participate in Medicare. BBA also modified the methodology used to determine plan payments, in part, because of concerns that (1) many health plans were overcompensated for the beneficiaries they served and (2) Medicare's managed care program had not, as originally anticipated, saved the program money. The new methodology is designed to both slow the growth of aggregate payments and more closely align per capita payments with the expected health care costs of plan members. BBA's creation of Medicare+Choice represents one important means of helping to address the growing challenge of financing the Medicare program. The Congressional Budget Office (CBO) has estimated that BBA's fee-for-service (FFS) and Medicare+Choice reforms will lower program spending by $386 billion over the next 10 years.

Some health plan and industry representatives believe that BBA's health plan payment changes were too severe and will reduce beneficiaries' access to plans and additional benefits, such as outpatient prescription drug coverage, that are not available under FFS. The American Association of Health Plans (AAHP) contends that Medicare will spend substantially less on health plan enrollees than for FFS beneficiaries, a discrepancy they term a "fairness gap." To assist congressional consideration of these concerns, you asked us to (1) review the extent to which health plans currently

provide additional benefits and whether they could continue to provide additional benefits if payments were reduced, (2) summarize the evidence regarding managed care's effect on Medicare spending, and (3) assess whether BBA provisions will eliminate excess plan payments. To answer these questions we analyzed data that plans submitted to the Health Care Financing Administration (HCFA) and synthesized findings from our previous reports and studies by HCFA, CBO, and others. Our work was done from May to June 1999 in accordance with generally accepted government auditing standards.

RESULTS IN BRIEF

Although all health plans are required to provide at least the package of benefits available in traditional FFS, most plans provide many more benefits--such as coverage for outpatient prescription drugs, routine physical exams, and dental care.[1] The extra benefits result, in part, because projected Medicare payments tend to exceed plans' estimated costs of providing the FFS package of benefits, and the program requires that the difference between payments and plan costs be used to fund additional benefits.[2] Data submitted by health plans indicate that they were required, on average, to provide additional benefits equivalent to nearly 13 percent of Medicare's payments in 1997. For competitive reasons, many health plans voluntarily enrich their benefit packages beyond Medicare's requirements. In 1997, the average enrollee in a health plan received more than $90 per month in required and voluntary additional benefits. Thus, even if plan payments were reduced, the typical plan could provide the FFS package of benefits as well as some additional benefits and still earn a profit.

Health plans have not, however, produced the expected savings for the Medicare program. Until 1997, Medicare plans were paid 95 percent of the expected FFS cost of beneficiaries. The 5-percent discount was established to allow the program to benefit from the efficiencies commonly associated with managed care. However, numerous studies conducted by us, the Physician Payment Review Commission (PPRC)--which has been incorporated into the Medicare Payment Advisory Commission--HCFA, and others demonstrated that the Medicare program spent more on beneficiaries enrolled

[1]Except where otherwise noted, this report uses the term "plan" to refer to organizations that receive a fixed monthly payment--known as a capitation payment--for each beneficiary they enroll regardless of that beneficiary's costs. Before BBA created the Medicare+Choice program, these organizations were known as risk-contract HMOs.

[2]Plans can provide additional benefits in the contract year or contribute to a stabilization fund, which the plan can draw on in future years to avoid fluctuations in its benefit package.

in health plans than it would have if the same individuals had been in FFS. This unexpected result occurred because Medicare payments were based on the estimated cost of FFS beneficiaries in average health and were not adequately adjusted to reflect the fact that plans tended to enroll beneficiaries with better-than-average health who had lower health care costs–a phenomenon known as favorable selection.

BBA's new formula for paying health plans–implemented in 1998–takes steps to lower, but probably not eliminate, excess plan payments. Among other changes, the new formula slows the growth of plan payment rates relative to FFS spending growth for 5 years. More importantly, BBA mandates the implementation of a health-based "risk adjustment" system intended to better match payments to beneficiaries' expected health care costs and reduce the excess payments caused by favorable selection. The effect of these changes is reduced, however, because BBA locked in place the excessive payment rates that existed in 1997. For example, when HCFA actuaries set 1997 payment rates, they based those rates on a forecast of 1997 FFS spending. The actuaries now know that those rates were too high because the forecast overestimated FFS spending by 4.2 percent. However, BBA specified that the 1997 rates be used as the basis for the 1998 rates. This implicit inclusion of the forecast error resulted in excess payments of $1.3 billion in 1998. Furthermore, the annual excess payments associated with the forecast error will increase each year as more beneficiaries join health plans.

BACKGROUND

As of June 1, 1999, about 6.9 million people–or approximately 18 percent of Medicare's 39 million beneficiaries–were provided care through managed care plans, most of which are capitated health plans.[3] Capitated plans receive a fixed monthly amount for each beneficiary, regardless of what individual enrollees' care actually costs. The remaining 82 percent receive health care on a FFS basis, under which providers are paid for each covered service they deliver to beneficiaries.

Inherent in Medicare's FFS program is an incentive for providers to deliver more services than necessary, driving up program costs. Policymakers have, therefore, looked to managed care–namely, the use of capitated plans–to curb unnecessary spending because these plans have a financial incentive to provide care efficiently. In fact, among BBA's major reforms to contain Medicare spending was the creation of

[3]About 90 percent of the 6.9 million Medicare beneficiaries were enrolled in managed care plans that receive fixed monthly capitation payments. The remainder were enrolled in plans that are reimbursed for the costs they incur, less the estimated value of beneficiary cost-sharing.

Medicare+Choice, which was intended to increase the plan options available to Medicare beneficiaries.

Before BBA changed the rate-setting process in 1998, the monthly amount Medicare paid plans for each plan member was directly tied to local spending in the FFS program. In general terms, the pre-BBA rate-setting methodology worked as follows. Every year, HCFA estimated how much it would spend in each county to serve the "average" FFS beneficiary. It would then discount that amount by 5 percent under the assumption that the managed care plans provided care more efficiently than the unmanaged FFS program. The resulting amount constituted a base county rate to be paid to the plans operating in that county. Because some beneficiaries were expected to require more health services than others, HCFA "risk adjusted" the base rate up or down for each beneficiary, depending on certain beneficiary characteristics--specifically, age; sex; eligibility for Medicaid; employment status; disability status; and residence in an institution, such as a skilled nursing facility.[4]

BBA substantially changed the method used to set the payment rates for Medicare plans. As of January 1, 1998, plan payment rates for each county are based on the highest rate resulting from three alternative methodologies: a minimum amount, a minimum increase over the previous year's payment rate, or a blend of historical FFS spending in a county and national average costs adjusted for local price levels. The changes were intended to address criticisms of the original payment system by loosening the link between local FFS spending increases and plan payment rate increases in each county. In addition, the establishment of a minimum payment rate was meant to encourage plans to offer services in areas that historically have had low payment rates and few participating plans--primarily rural counties. BBA also directed the Secretary of Health and Human Services to develop and implement a better risk-adjustment system based on beneficiary health status by January 1, 2000.

MEDICARE+CHOICE PLANS PROVIDE ADDITIONAL BENEFITS BECAUSE MEDICARE PAYMENTS EXCEED PLANS' COSTS

For many beneficiaries, health plans cost less than traditional FFS and offer a more comprehensive benefit package. For example, beneficiaries in plans often pay a small copayment each time they use an outpatient service but are generally not responsible for the deductibles and coinsurance amounts they would pay in FFS. The out-of-pocket cost for a plan enrollee is often lower than the premium for a supplemental, or

[4]Separate rates are calculated for beneficiaries who qualify for Medicare because of a disability (under age 65) and the aged. Separate rates are also set for beneficiaries with end-stage renal disease (kidney failure).

Medigap, insurance policy–another way that beneficiaries obtain increased coverage. The trade-off is that beneficiaries must generally use only plan-approved providers and abide by other plan rules to receive covered services.

More than two-thirds of all beneficiaries live in areas served by at least one health plan. About 85 percent of these beneficiaries could enroll without paying a separate monthly premium and 88 percent have access to a plan that provides coverage for outpatient prescription drugs.[5] All, or nearly all, beneficiaries who could join a plan have access to a plan that offers coverage for routine physical, eye, and hearing exams. Many of these beneficiaries have access to a plan that also provides dental care.

One reason for the enhanced benefit packages is that plans' estimated cost of providing the traditional FFS benefit package–including the amount of profit normally earned on commercial contracts–tends to be lower than Medicare's projected payment.[6] Under Medicare's payment terms, when a plan's estimated cost to provide the FFS package of benefits is less than projected payments, the plan must use the difference–an amount known as "savings"–to enhance its benefit package by adding benefits or reducing cost-sharing.[7] In 1997, plans' savings averaged nearly 13 percent of payments. Consequently, plans were required to provide additional benefits worth $60 per member per month.

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[5]Beneficiaries who wish to participate in the Medicare+Choice program must pay the Medicare part B premium of $45.50 per month. (See Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues (Apr. 27, 1999, GAO/HEHS-99-91.)

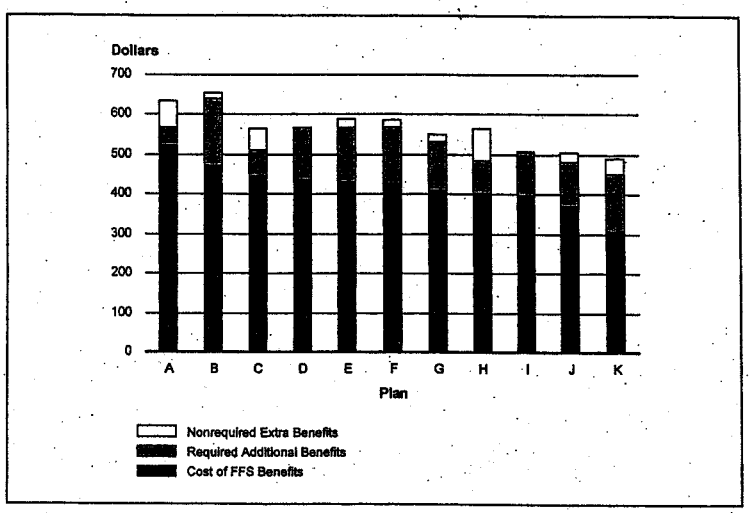
[6]The accuracy of the cost data submitted by plans is unknown. Recent reports by the Department of Health and Human Services' Office of the Inspector General suggest that the administrative cost component for some HMOs may be too high and that, consequently, the amount of required additional benefits may be too low. (See Department of Health and Human Services, Office of the Inspector General, Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated A-14-97-00202 (July 1998).)

[7]Alternatively, plans may deposit the amount in a benefit stabilization fund for use in future years. Before 1998, plans had a third option of returning the savings to Medicare. Historically, however, plans have enhanced their benefit packages in an attempt to attract members.

Although the relationship between plans' costs and their Medicare payments may have changed since 1997, our analysis of 1999 data submitted by plans serving Los Angeles County suggests that the estimated costs of some plans continues to be well below Medicare projected payments. On average, Los Angeles plans could provide the FFS package of benefits for 79 percent of the current payment amount. They complied with Medicare's requirements by using the approximately $117 per beneficiary per month difference between Medicare payments and their costs to provide additional benefits. (See fig. 1.) This amount of additional benefits may be higher than the national average because of the historically high payment rates in the area. However, the example of Los Angeles illustrates that, in the second year of BBA's payment reforms, some plans' projected payments far exceed their estimated costs of providing the traditional FFS benefit package.

B-282937

Figure 1: Los Angeles Plans' Estimated Costs of Providing Medicare FFS Benefit Package, Required Additional Benefits, and Nonrequired Extra Benefits Provided, 1999



Note: Medicare's payments vary by plan because of variations in plans' geographic service areas (although each plan's service area includes Los Angeles county) and the demographic characteristics of plans' members.

Source: GAO analysis of 1999 adjusted community rate proposal data submitted to HCFA by Medicare+Choice plans.

Plans may also choose, for competitive or other reasons, to exceed Medicare's minimum requirements and further enhance their benefit packages. Nationally, plans added more than $33 in extra benefits per member per month–in addition to the $60 in required additional benefits–in 1997.[8] The Los Angeles plans added an average of $21

[8]On average, plans reported voluntarily providing $33 in additional benefits. Many plans, however, further enhanced their benefit packages in certain parts of their

per beneficiary per month in extra benefits during 1999. Although all Los Angeles plans offer some extra benefits, the dollar amount varies by plan from $0.43 per beneficiary per month to $80 per beneficiary per month. The ability of plans to provide additional benefits (both required and voluntary) suggests that planned cuts in rate increases may not threaten the typical plan's ability to earn a profit while providing a benefit package that is more comprehensive than the one available in Medicare FFS.

Plans' benefit packages may be especially attractive to beneficiaries when contrasted with private supplemental insurance, known as Medigap.[9] Medigap policies generally cost beneficiaries $95 per month or more and provide less extensive coverage than many plans. For example, although most of the 10 standard Medigap policies cover Medicare's coinsurance and hospitalization deductible amounts, only three of the standard policies cover outpatient prescription drugs. These policies require a $250 deductible with a 50-percent copayment, and coverage is capped at a fixed annual dollar amount. In contrast, some managed care plans offer unlimited coverage for prescription drugs with minimal copayments and no deductible. These differences suggest that even if plans charged a significant premium, they may still be cheaper and provide more comprehensive coverage than a Medigap policy for many beneficiaries.

MEDICARE'S MANAGED CARE OPTION SUBSTANTIALLY INCREASED PROGRAM SPENDING

Although Medicare's pre-BBA payment methodology based plan payments on FFS spending discounted by 5 percent, beneficiary enrollment in plans did not produce savings for the program. In fact, evidence from several studies shows that Medicare's managed care option substantially increased program spending. In general terms, this result occurred because plans enrolled healthier-than-average beneficiaries while Medicare's methodology based payments on the estimated FFS cost of serving the average beneficiary and the payment adjustments did not adequately reflect this favorable enrollment.

On average, Medicare beneficiaries enrolled in plans are in better health and need less care than beneficiaries in the FFS program. In a 1996 beneficiary survey, approximately 81 percent of HMO enrollees report their health status as good or better

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geographic service areas. The dollar amount of these enhancements is not included in the $33.

[9]Approximately 34 percent of beneficiaries in FFS purchase Medigap policies. Approximately an additional 53 percent have coverage through an employer-sponsored plan or other plan or the Medicaid program.

while 19 percent indicated that their health was fair or poor.[10] Among the beneficiaries in FFS, 70 percent assessed their health as good or better, while 30 percent responded that their health was fair or poor. Moreover, 11.7 percent of FFS beneficiaries reported that they had three or more activity of daily living (ADL) limitations (ADLs include such activities as eating and bathing), whereas only 4.9 percent of HMO enrollees reported a similar number of ADLs. The survey also found that better health translates into lower health care costs. In 1996, average FFS spending per beneficiary in excellent to good health ranged from about $2,130 to $4,430. In contrast, average FFS spending was approximately $7,030 for a beneficiary in fair health and $11,740 for a beneficiary in poor health.

The problem is not that beneficiaries in plans tend to be healthier than beneficiaries in FFS, but that Medicare's current risk adjustment methodology–based on simple demographic characteristics, such as age and sex–does not sufficiently adjust payments to reflect that fact.[11] For example, the estimated FFS cost of an average 74-year-old male not living in an institution or receiving Medicaid was about $581 per month in Los Angeles County in 1997. Of course, some 74-year-old males suffer from serious chronic conditions and need much more care, while others may experience only occasional minor ailments and need much less care. Plans that attracted a disproportionate number of healthier 74-year-olds would be overcompensated because they would incur much lower costs but still receive about $552 (95 percent of $581) per month per member. Alternatively, plans that attracted the less healthy, higher cost 74-year-olds would be undercompensated. Because relatively few beneficiaries account for the majority of Medicare spending (10 percent of the elderly beneficiaries account for 63 percent of Medicare spending on the elderly), a plan's costs can be greatly affected to the extent that it enrolls beneficiaries from this group.

The financial consequences of a poor risk adjustment methodology in the presence of favorable selection are huge. For example, in our 1997 study of Medicare payment rates in California, we estimated that the program paid about $1 billion in excess payments to health plans in that state in 1995.[12] On average, Medicare overpaid plans by about 16 percent, but this percentage varied by county. For example, we estimated that plans in Los Angeles were overpaid by nearly 21 percent. About one-quarter of

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[10]Medicare Current Beneficiary Survey, 1996, as reported in HCFA, A Profile of Medicare: Chartbook 1998 (May 1998).

[11]HCFA has long recognized the inadequacies of the current risk adjustment system and funded research on alternative approaches.

[12]Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

the excess payments occurred because HCFA's methodology for setting base rates in each county did not take into account the effect of favorable selection. In the presence of favorable selection, HCFA's method tended to overestimate per-beneficiary average cost because it included the costs of the generally less healthy, more expensive FFS beneficiaries and excluded the costs of the generally healthier, less expensive plan enrollees. Our study found that, partly as a result of this flawed methodology, excess payments as a percent of total payments tended to be highest in counties with a large proportion of beneficiaries in managed care plans. This finding suggests that aggregate excess payments likely increased since 1995 as managed care enrollment grew.

Other studies have also concluded that Medicare's current risk adjustment methodology does not adequately reflect the generally healthier status of plan enrollees and results in excess payments to plans. For example, in a 1996 study based on 1994 data, HCFA researchers estimated that managed care enrollees' expected FFS costs were 12 to 14 percent below average, after adjusting for their demographic characteristics. Based on those findings, PPRC in its 1997 Annual Report to Congress estimated that an improved risk adjustment method could save Medicare $2 billion per year.[13] A comprehensive study by Mathematica Policy Research, Inc., based on 1990 data found that enrollees' costs were approximately 11 percent below average, after adjusting for demographic traits. Moreover, Mathematica's results may underestimate the cost differences because its study excluded the costs of beneficiaries who died during the year. Because end-of-life health care is expensive and mortality rates in plans are much lower than in FFS, the exclusion of this group of beneficiaries likely reduced the estimated per-beneficiary cost differences between plans and FFS.

In contrast to almost all other studies, a 1996 study commissioned by AAHP and conducted by Price Waterhouse (PW) found little favorable selection among Medicare enrollees, concluding that health plans enroll both healthy, low-cost beneficiaries and chronically ill, high-cost beneficiaries.[14] However, a CBO analyst in a 1996 memorandum argued that ". . . the findings in the PW study are not credible because of flaws in the data and methods used. Adjustment for obvious biases in the PW results would more than quadruple its estimate of favorable selection."[15]

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[13]PPRC's 1996 Annual Report to Congress contains a detailed table of studies on favorable selection (table 15-1).

[14]Jack Rodgers and Karen Smith, Is There Biased Selection in Medicare HMOs? (Washington, D.C.: Health Policy Economics Group, Price Waterhouse LLP, Mar. 14, 1996).

[15]Biased Selection in Medicare's HMOs, CBO memorandum dated July 17, 1996.

BBA PAYMENT REVISIONS LIKELY HAVE NOT ELIMINATED EXCESS PAYMENTS

Beginning in 1998, BBA substantially changed the method used to set health plan payments. Some of the new payment provisions are designed to reduce excess payments, while others are designed for different purposes–such as increasing plan participation in geographic areas that had low payment rates. The most important of the cost-reducing changes is a new health-based risk adjustment system, to be implemented in 2000. Substantial excess payments may persist, however, because the excess that existed in 1997 was incorporated into the base rates.

One way BBA aims to reduce the excess in Medicare's health plan payments is by holding down per capita spending increases for 5 years. Specifically, BBA sets the factor used to update managed care payment rates to equal the national per capita Medicare growth minus a specified percent: 0.8 percent in 1998 and 0.5 percent in each of the following 4 years. This across-the-board type of approach can produce savings. The cumulative reduction of less than 3 percent, however, is considerably smaller than the prior estimates of excess payments, which generally exceed 10 percent. Moreover, this approach does not address the problem that the excess payments can vary among geographic areas and plans. In our study of California health plans, we found that excess payments tended to be much higher in some counties than in others.

BBA also provides for a methodological approach known as "blending," which is designed to reduce the geographic disparity in payment rates and encourage more widespread plan participation.[16] Blending will work over time to move all rates closer to a national average by providing for larger payment increases in low rate counties and smaller payment increases in high rate counties. According to a 1997 PPRC study, there is some evidence that excess payments are more likely to occur in high payment rate counties. Thus, blending may indirectly reduce excess payments by holding down payment increases in high rate counties.

BBA's mandated health-based risk adjustment system is the provision that most directly targets the excess health plan payment problem. BBA requires HCFA to

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[16]Because of low growth in Medicare spending and BBA's budget neutrality and minimum payment requirements, no county received a blended rate in 1998 or 1999. According to HCFA actuaries, the blending provision could not be funded because BBA's minimum payment requirements resulted in total plan spending that exceeded BBA's mandated budget neutrality provision by $95 million in 1998 and $80 million in 1999. Blending will occur for the first time in 2000.

implement, beginning January 1, 2000, a method to adjust plan payments based on beneficiary health status. Although HCFA's proposed interim health-based risk adjustment method uses only hospital inpatient data to gauge beneficiary health status, it still represents a major improvement over the current method.[17] For the first time, plans can expect to be paid more for serving Medicare beneficiaries with serious health problems and less for serving relatively healthy ones.

HCFA proposes to phase in the new interim risk adjustment system slowly. In 2000, only 10 percent of health plans' payments will be based on the new system. This percentage will be increased each year until 2003, when 80 percent of plans' payments will be based on the interim system. In 2004, HCFA intends to implement a more accurate risk adjuster that uses medical data from physician offices, hospital outpatient departments, and other health care settings and providers–in addition to inpatient hospital data. This type of risk adjustment system cannot be implemented now because many health plans report that they do not have the capability to provide such comprehensive information. Although a gradual phase-in of the interim risk adjuster delays the full realization of Medicare savings, it also minimizes potential disruptions for both health plans and beneficiaries.

BBA may not eliminate excess payments, however, in part because the law specified that 1997 county rates be used as the basis for all future county rates beginning in 1998. In effect, BBA tended to lock in prior excess payments. As we reported in 1997, HCFA's then current methodology ignored the effects of favorable selection and resulted in county rates that were generally too high.[18] In addition, excess payments are built into the current rates because BBA did not allow HCFA to adjust the 1997 county rates for previous forecast errors. Such adjustments had been a critical component of the pre-BBA rate-setting process. HCFA actuaries now estimate that the forecast error resulted in 1997 managed care rates that were 4.2 percent too high. While BBA permits HCFA to correct forecasts in future years, it did not include a provision that would have allowed HCFA to correct its forecast for 1997. Consequently, according to HCFA actuaries, about $1.3 billion in excess payments were built into plans' annual payment rates in 1998. Furthermore, these excess payments remain in the base rates and will grow over time as health plan enrollment grows.

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[17]Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans (GAO/T-HEHS-99-72, Feb. 25, 1999).

[18]GAO/HEHS-97-16.

CONCLUSIONS

Beneficiaries who enroll in health plans typically reduce their out-of-pocket costs and receive coverage for benefits, such as outpatient prescription drugs, that FFS Medicare does not cover. If these extra benefits resulted exclusively from the efficiencies of health plans, then there would be no cause for taxpayers to be concerned. However, the evidence shows that Medicare's payments are too high and that plans turn these excess payments into extra benefits to attract beneficiaries. Instead of producing savings as originally envisioned, Medicare's managed care option has added substantially to program spending.

Fortunately, extra benefits for Medicare beneficiaries and program savings are not mutually exclusive goals. According to their own data, some plans could make a normal profit and provide enhanced benefit packages even if Medicare payments were reduced. The resulting benefit packages may not be as rich as they are today, but they could still be more generous than the FFS package and cost beneficiaries less than an equivalent Medigap policy.

Achieving program savings while preserving extra benefits for beneficiaries enrolled in plans requires an improved risk adjustment system that more closely matches plan payments to the expected health care costs of the beneficiaries they serve. HCFA is working on implementing an improved risk adjustment system in 2000. However, achieving the two goals also requires that the base payment rate accurately reflects the cost of serving the average beneficiary. Our work indicates that the current base rates are too high because they incorporate the excess payments that were present in 1997. Thus, as we previously reported, correcting the base rates is necessary to prevent continuing excess payments.

In 1997, we recommended that the Secretary of Health and Human Services take action to reduce excess plan payments by directing the HCFA Administrator to revise the agency's methodology for establishing base payment rates in each county. Shortly after we made our recommendation, the Congress enacted BBA. The new law included several provisions, such as reduced annual updates and health-based risk adjustments, that will help to reduce excess payments. However, by specifying that the 1997 rates be used to determine future rates, it also tended to lock in place the pattern of excess payments that existed in 1997.

MATTERS FOR CONGRESSIONAL CONSIDERATION

To avoid unnecessary Medicare spending, the Congress may wish to consider revising each county's base rate to more accurately reflect the estimated fee-for-service cost of serving the average Medicare beneficiary. Such a revision would eliminate

Medicare+Choice and FFS spending disparities caused by (1) flaws in the methodology HCFA used to set base rates in each county before BBA, (2) the incorporation of the 1997 forecast error in 1998 and future rates, and (3) the annual payment rate update reductions mandated by BBA. If the Congress wishes to share in the efficiencies of Medicare+Choice plans, base rates should be set below estimated average FFS costs as they were under the Medicare risk-contract program. The Congress may also want to consider maintaining a minimum base rate to encourage greater participation by Medicare+Choice plans in rural areas.

AGENCY COMMENTS

In commenting on our report, HCFA agreed that the available evidence indicates that Medicare's manage care option has substantially increased program spending. HCFA stated that the most recent evidence of favorable selection and excess plan payments can be found in its March 1999 report to the Congress on risk adjustment. The agency also agreed with our finding that the typical plan could continue to provide benefits beyond those covered by part A and part B of Medicare, even if payments are reduced. Finally, HCFA concurred that excess payments will be lowered, but not completely eliminated, by BBA's new formula for paying health plans.

In response to our matters for congressional consideration regarding revising base rates, HCFA suggested that careful consideration first be given to the potential impact on beneficiaries and plan participation in Medicare+Choice. It noted that some BBA payment revisions, including the new risk adjustment system, have yet to be implemented. The agency agreed, however, that correcting the forecast error built into the 1997 rates would help reduce excess payments.

BBA reflects the Congress' intentions of achieving Medicare savings, partly by reducing excess plan payments. Revising base rates so that they more accurately reflect the cost of serving beneficiaries is an important step in reaching that goal. Although we agree that the impact on beneficiaries and plans should be carefully considered, we believe that base rate revisions could be accomplished with minimal disruptions by phasing in the changes–in much the same way that the interim risk adjustment system will be phased in.

HCFA also provided a number of technical comments, which we incorporated as appropriate. HCFA's comments are reprinted in appendix I.

Medigap, insurance policy–another way that beneficiaries obtain increased coverage. The trade-off is that beneficiaries must generally use only plan-approved providers and abide by other plan rules to receive covered services.

More than two-thirds of all beneficiaries live in areas served by at least one health plan. About 85 percent of these beneficiaries could enroll without paying a separate monthly premium and 88 percent have access to a plan that provides coverage for outpatient prescription drugs.[5] All, or nearly all, beneficiaries who could join a plan have access to a plan that offers coverage for routine physical, eye, and hearing exams. Many of these beneficiaries have access to a plan that also provides dental care.

One reason for the enhanced benefit packages is that plans' estimated cost of providing the traditional FFS benefit package–including the amount of profit normally earned on commercial contracts–tends to be lower than Medicare's projected payment.[6] Under Medicare's payment terms, when a plan's estimated cost to provide the FFS package of benefits is less than projected payments, the plan must use the difference–an amount known as "savings"–to enhance its benefit package by adding benefits or reducing cost-sharing.[7] In 1997, plans' savings averaged nearly 13 percent of payments. Consequently, plans were required to provide additional benefits worth $60 per member per month.

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[5]Beneficiaries who wish to participate in the Medicare+Choice program must pay the Medicare part B premium of $45.50 per month. (See Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues (Apr. 27, 1999, GAO/HEHS-99-91.)

[6]The accuracy of the cost data submitted by plans is unknown. Recent reports by the Department of Health and Human Services' Office of the Inspector General suggest that the administrative cost component for some HMOs may be too high and that, consequently, the amount of required additional benefits may be too low. (See Department of Health and Human Services, Office of the Inspector General, Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated A-14-97-00202 (July 1998).)

[7]Alternatively, plans may deposit the amount in a benefit stabilization fund for use in future years. Before 1998, plans had a third option of returning the savings to Medicare. Historically, however, plans have enhanced their benefit packages in an attempt to attract members.

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Abbreviations

AAHP American Association of Health Plans
ADL activity of daily living
BBA Balanced Budget Act of 1997
CBO Congressional Budget Office
FFS fee-for-service
HCFA Health Care Financing Administration
HMO health maintenance organization
PPRC Physician Payment Review Commission
PW Price Waterhouse

COMMENTS FROM THE HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 17 1999

TO: Laura A. Dummit, Associate Director
Health Financing and Public Health Issues, GAO

FROM: Nancy-Ann Min DeParle
Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare+Choice: Reforms Have Reduced, But Likely Not Eliminated Excess Plan Payments" (GAO/HEHS-99-144)

One of the Health Care Financing Administration's highest priorities is ensuring the provision of the highest quality service to Medicare beneficiaries in a cost-efficient manner. To this end, HCFA continues to look for ways to improve the Medicare+Choice program and the original fee-for-service program.

We appreciate the opportunity to review your draft report to Congress concerning the issue of excess payments to health care plans. The overall findings seem consistent with our belief that there is evidence demonstrating that Medicare's payments are too high and that plans use these excess payments to provide extra benefits for beneficiaries.

Regarding the General Accounting Office's suggestion that the Congress examine alternative methods for reducing excess payments, HCFA believes that any such changes should be carefully considered, given the potential impact on beneficiaries and on plan participation in the Medicare+Choice program. Also, under the Balanced Budget Act of 1997, HCFA has taken steps to improve the methodologies used to pay plans. We will continue to review this situation carefully, and we look forward to working with GAO on this issue.

Thank you again for preparing such a valuable overview on this important topic.

APPENDIX I

Comments of the Health Care Financing Administration (HCFA)
on the General Accounting Office (GAO) Draft Report:
"Medicare+Choice: Reforms Have Reduced, But Likely
Not Eliminated Excess Plan Payments"

The Balanced Budget Act of 1997 (BBA) created a new Medicare+Choice program so that health maintenance organizations (HMOs) and other private health plans can contract to enroll Medicare beneficiaries. Among other changes to the Medicare risk plan program in effect since 1985, the new Medicare+Choice program modified the payment methodologies used to for Medicare risk plans. The General Accounting Office (GAO) was asked to report on three issues in order to assist in congressional consideration of concerns raised by health plan and industry representatives regarding the BBA's payment methodology for determining Medicare+Choice payments. We appreciate the opportunity to review and comment on the report.

(1) The GAO was asked to review the extent to which health plans currently provide additional benefits and whether they can continue to provide additional benefits if payments were reduced.

We agree with the GAO's findings that payments will continue to allow plans to provide benefits beyond those covered by Part A and Part B of Medicare for a premium that is less than that charged by Medigap plans for comparable benefits.

(2) The GAO was asked to summarize the evidence regarding managed care's effect on Medicare spending.

We agree with GAO's conclusion that, "evidence from several studies shows that Medicare's managed care option substantially increased program spending." We would recommend that GAO include in its discussion a summary of the latest evidence of risk selection from in HCFA's March 1999 Report to Congress on risk adjustment. The analysis in this report is consistent with other studies documenting favorable selection into Medicare managed care plans.

(3) The GAO was asked to assess whether the Balanced Budget act of 1997 (BBA) provisions will eliminate excess plan payments.

We agree with the GAO that excess payments will be lowered, but not completely eliminated, by the BBA's new formula for paying health plans. We also agree that excess payments could be further eliminated by making an adjustment to the 1997 base rates, which include a 4.2 percent overestimate (which cannot be corrected without a change in statute).

APPENDIX I

GAO MATTERS FOR CONGRESSIONAL CONSIDERATION

In this section of the report the GAO suggests that Congress should consider taking steps to reduce Medicare payments to health plans. It is worth noting that the BBA made major changes in payment to Medicare health plans only two years ago. Blended rates will be applicable for the first time in 2000. In addition, in 2000 we will begin a five-year transition to risk adjusted payment. We, therefore, believe that any significant revisions to the base rates should be carefully considered, given the potential impact on beneficiaries and on plan participation in the Medicare+Choice program. We would like to take this opportunity to note, however, that the implementation of risk adjustment as mandated by the BBA addresses directly the specific issue previously raised by GAO in its 1997 report regarding appropriate payment for managed care enrollees. Therefore, we believe that there is no need to adjust the base as previously recommended by GAO.

(101820)

Mr. BROWN. Based on this document—and, I mean, it is pretty clear that there is a significant body of evidence that some HMOs are continuing to be overpaid. As you recall, Dr. Moon, prior to the BBA of 1997, the GAO stated that we were overpaying managed care plans significantly, but that seems perhaps to have gotten better but not significantly better.

There was a—the document from the SEC, from the Securities Exchange Commission, states about one managed care company has done particularly well. Their filings as a result of the premiums differences, the Secure Horizons program, accounted for approximately 59 percent of our—document from the company, itself—"59 percent of our consolidated premium revenue for the year ended December 31, 1998, an even larger percentage of our operating profit, even though it represented only 28 percent of our total membership."

So this company, 59 percent of its revenue profits and large percentage of its profits came from 28 percent of its total membership, moneys paid by HCFA.

What does this tell us about overpay? Could you talk about how, even with the BBA of 1997, how overpayment has continued?

Ms. MOON. The issue of overpayment I believe is very closely related to the question of who enrolls in managed care plans. And, as Karen Ignagni pointed out earlier, plans that have, for example, patients that have stayed in for a number of years and are older and have more health care problems are probably closer to the average Medicare beneficiary population, but there are many plans that have a much healthier population. It's not just age, it's not just the basic characteristics, it really is the question of what are the needs of the people that are in those plans.

That's one of the reasons why I think that risk adjustment is an extremely important way of leveling the playing field in terms of payments to plans.

That really has driven a lot of the differential over time, as well as some other differences, so I think that one of the key questions is, how do you find reasonable ways to deal with overpayment, recognizing that it is not uniform? It certainly, as other people have pointed out, varies a lot, and in some places will be extremely high and other places probably managed care plans are being paid correctly, and in some cases they probably have a case for some higher payment.

One of my concerns is an across-the-board remedy that ignores, I think, some of these important differences.

Mr. BROWN. Is there any way to pay managed care plans appropriately without risk adjusting?

Ms. MOON. I don't believe there is, and I think it is going to be a continued struggle to find a good risk adjustment mechanism. We're not there yet. It is going to be clearly a problem as long as the incentive is there where, if plans can make money by attracting good risks, that's not a healthy situation either for plans, for Medicare, or for beneficiaries. What you'd really like to do is see a world in which the advantages of coordination of care, which I think can be substantial for sicker patients, are truly rewarded in the Medicare+Choice program.

Mr. BROWN. So you could do that through risk adjusting. And can you do it other ways? What other mechanisms do we use to match that more appropriately?

Ms. MOON. There are other issues, I think, that are clearly important in terms of a good, balanced structure. One that the Medicare program now has is a requirement that managed care plans take people who want to enroll in them. You want to have everyone have access to the plan and not deny them, and that does not seem to be a problem.

I think standardization of benefits, at least some critical benefits like prescription drugs, are also very important. Prescription drugs are an interesting dilemma because managed care plans I think are kind of caught here.

Right now, if they offer very generous prescription drug benefits, they may attract a sicker population and that may cause them to back off from that, as we've seen in terms of caps on the prescription drug coverage being very extensively used by managed care plans.

Mr. BROWN. The plans are saying—Mr. Chairman, one more question—the plans are saying, Dr. Moon, that they are getting $11 billion in cuts from risk adjustment. Is that only if they keep the same mix of enrollees that is sort of—the mix is tilted toward more-healthy beneficiaries?

Ms. MOON. That's my understanding of how that $11 billion works. I have to say I haven't gone and analyzed this in detail, and I think it is important to monitor this carefully.

But if you have an average mix of patients that look like the Medicare population, in general, in terms of health status, then plans should be budget neutral.

If plans start out with a much healthier mix of people, then it seems to me you don't want to have budget neutrality; you would want to make sure that your risk adjustment mechanism is ratcheting down.

So I think it needs careful monitoring, but I think there is nothing magic, necessarily, about a budget neutral risk adjustor. In fact, it may not be a good way to go.

Mr. BROWN. Thank you.

I think, Mr. Chairman, that's exactly the point. If risk adjustment means major cuts to plans, it means it is because those plans, by and large, were cream skimming, were attracting healthier beneficiaries.

If they have more of a cross-section of—as Dr. Moon said, if they have more of a cross-section of enrollees, then pretty clearly, by definition, it is going to be revenue neutral, they're not going to face those cuts.

Thanks.

Mr. BILIRAKIS. I thank you.

Mr. Bryant?

Mr. BRYANT. Thank you, Mr. Chairman.

I want to thank our very qualified panel. I appreciated your testimony.

Let me ask, Mr. Powell, on behalf of the Senior Coalition, I take it you are supportive of this budget neutral arrangement where we don't lose the $11 billion, $11.2 billion?

Mr. POWELL. That's correct. Yes.

Mr. BRYANT. Ms. Canja, the AARP—for which I qualified this year and got your very kind invitation—you have a different view of that, and I'm not sure I agree with that, but at this point you are saying that you are comfortable with the potential for the cuts of $11.2 billion?

Ms. CANJA. As I said, we have supported, after observing what HCFA was doing, we did support the action. In listening to the conversation, it does make sense that those that did not have beneficiaries who were sicker or more frail, or whatever, and needed more care, they would not benefit from risk adjustment.

But I still say that we have our staff here and they've been working with the committee and will do so.

Mr. BRYANT. Thank you.

Ms. Ignagni, did I understand you correctly that the fee-for-service, do they get an increase of 5.8 percent——

Ms. IGNAGNI. Yes, sir.

Mr. BRYANT. [continuing] per year, or is that 2 years?

Ms. IGNAGNI. No, that's per year.

Mr. BRYANT. Per year?

Ms. IGNAGNI. For this year coming up.

Mr. BRYANT. As contrasted to the 2 percent that managed care——

Ms. IGNAGNI. In many communities.

Mr. BRYANT. Right.

Ms. IGNAGNI. And in some communities it is below 2.

Mr. BRYANT. And also you industry is subject to those regulations.

Ms. IGNAGNI. Yes, sir.

Mr. BRYANT. I mentioned those to the first panel, the 800 pages, the 42 letters, and that the fee-for-service is not subject to all that?

Ms. IGNAGNI. That's right.

Mr. BRYANT. I know several panelists have mentioned—even the first panelist mentioned this playing on a level field, and that's a key phrase I've picked up in Washington. Everybody wants a level playing field, like don't let the good be the enemy of the perfect. That means you're about to get it, I think. And the level playing field, I'm not sure what that means.

But, you know, just those two items, alone—the rate of increase a year and the amount of regulation—doesn't seem to be very level to me.

I'm concerned about the rural areas of Tennessee. I represent a very urban part of Shelby County and Memphis, but I also have 14 counties that are less urban, more rural, and the fact that some of the people in the Medicare+Choice groups have moved out of Tennessee.

The first panelist mentioned that we're subject to a lower rate in Tennessee, and Dr. Ganske mentioned Iowa the same way.

I want this choice available for my constituents in Tennessee, and I'm concerned. How do we get that? Is it by cutting $11.2 billion from the program?

Ms. IGNAGNI. I think if you proceed forward with risk adjustor, what you have done is you've created a hospital adjustor. That's all it is. As you get into the issue and you look at it, I'm not sure that

any economist, as they study this—you use the weights in the fee-for-service system to develop this risk adjustor, which completely devalues any type of care for the chronically ill that has been provided on an outpatient basis.

So, to the extent the rabbi would receive congestive heart treatment on an outpatient basis, no credit for that.

I've just come from a diabetes conference, 500 people in Washington in August—no credit for that on an outpatient basis—only if you hospitalize, and only if you hospitalize for more than 1 day.

I think there are very legitimate technical issues. We've been in long conversations with HCFA. I do believe they agree with many of the technical concerns.

Many individuals have said it was the best they could do. It's not adequate. You voted on $22 billion of cuts in this sector. It is adding another 11.5—further and further developing the problems associated.

In your area—I have a run of all the members and what the situation would be in each of their counties—there is only one county in your area which would receive an increase over 100 percent, and that's a very rural county where you only have two enrollees. In every other county you're down in very, very significant terms relative to fee-for-service, so it explains precisely why there is not the purchasing power adequacy to continue to operate this program over time.

And so you are right to ask the question, you're right to be concerned, and I think that that's really what the task of this committee is going to be—and it is tough. There's no question about it—to look through all these issues, but look at the purchasing power adequacy.

Mr. BRYANT. If I might just close quickly with a statement, I know whether it is Medicare+Choice or whether it is fee-for-service, I will reiterate, as I did with the first panel, that the health care providers, the doctors, the hospitals in my District, are very, very concerned about what they are being paid already and how far they have been cut.

Ms. IGNAGNI. Yes, I know. Right.

Mr. BRYANT. And they are just—and the amount of paperwork they have to go through.

Ms. IGNAGNI. Right.

Mr. BRYANT. I yield back the time.

Mr. BILIRAKIS. Mr. Deutsch?

Mr. DEUTSCH. Thank you, Mr. Chairman.

Ms. Ignagni, if you could follow up on what you just said, and maybe try to be a little bit clearer on it, that the risk adjustment, in fact, if we look at what HMOs, in general, are trying to do, they're trying to be more efficient and literally keep people out of the hospitals, do more operations when it is more efficient, do shorter hospital stays when it could be more efficient. So just, at a practical—I mean, this concept is a wonderful sort of concept, and I agree completely with what Dr. Moon said that ultimately that's really how you theoretically have to go.

Ms. IGNAGNI. Right.

Mr. DEUTSCH. I mean, in this perfect world, people are to be reimbursed for how much it should theoretically cost you to treat

them, sort of a DRG-type system. But at the practical level, you know, can you elaborate a little bit on what this risk adjustor we are actually using does and how, in a sense, it unfairly penalizes people who are being efficient.

Ms. IGNAGNI. It completely turns on its head all of the progress that has been made over the last 10 years to treat the chronically ill on an outpatient basis, because plans who are doing that would receive no extra payment, so it completely devalues what we have accomplished in terms of care management and what the literature says is a more-productive way to go about treating people.

I think that many haven't had the opportunity to look into the details of this to see that, in fact, what you have here is a hospital adjustor. You don't have a risk adjustor. We've gone beyond that in our delivery system. The fee-for-service system has to catch up. Building a risk adjustment system based on fee-for-service makes no sense whatsoever.

Mr. DEUTSCH. Dr. Moon, could you follow up, just in terms of the status of it, in terms of the incentives and everything else?

Ms. MOON. The goal of a risk adjustment mechanism is to try to find a way to adjust for differences in health status, and Karen is quite right that this particular system is not an ideal system, and I think almost everyone believes it is an interim approach.

There is a certain dilemma here. Part of the problem is that it is based on fee-for-service information because we don't have a clue what is going on in managed care plans, and we need information on that, and that has not been an area that has been possible to get information from.

But it is also the case and my understanding is that, on average, this does a better job of adjusting for differences in health status, and so it is a step in the right direction.

The current system we have is totally inadequate. This is a little less inadequate. And then the ideal is to move further into the direction.

I don't believe it has an incentive for hospitalization, however.

Mr. DEUTSCH. Okay. Let me—there are two other areas that I want to at least touch on in the 5 minutes. Congressman Brown talked about, I guess theoretically, the idea that the $11.2 billion savings wouldn't be as large if it turns out that HMOs are treating sicker people or not-healthier people.

I mean, is there any indication, you know, the percentage of healthy people, the percentage that we have statistical data that we can look at in terms of people who are in HMOs today, percentage-wise, healthier versus the average Medicare population, Ms. Ignagni?

Ms. IGNAGNI. No. In fact, all the data that we have are very old and reflect what was going on in the delivery system in the early 1990's.

The PPRC data, which is 1995 data published in 1996 that was made reference to this morning, actually shows that there was quite a great deal of catch-up in the Medicare+Choice plan—then it was Medicare risk—relative to the early days of the 1990's, and you weren't seeing those broad differences that were indicated by the Mathetmatica Corporation when they did their original research.

We don't have data today, and this is the problem. I would just urge you to consider what's going on in the market as a proxy for what may be totally inadequate with results of this formula and its implementation.

Mr. DEUTSCH. So, again, we're talking about these risk adjustment and the savings really based upon no practical—I mean, is that fair?

Ms. IGNAGNI. No. HCFA published a table. Here it is, Health Care Financing Administration. Virtually no plan receives any credit under the risk adjustor analysis that was done in the proposal developed by HCFA. This was distributed by HCFA several months ago in the spring, and it indicates exactly what we're saying—that the entire risk adjustment proposal that was developed by HCFA, not written by this Congress but developed by HCFA, is totally based on whether or not you hospitalize a patient, because you don't get any credit for any of the chronically ill programs you're running on an outpatient basis.

Mr. DEUTSCH. Which really does seem like a fundamental——

Ms. IGNAGNI. It turns the whole thing on its head, and I can't imagine that beneficiaries, when they find out about how this works, would be supportive of that.

Mr. DEUTSCH. Mr. Chairman, if I can just have one last question. The last question relates to this whole issue of, you know, how much savings or what's the reimbursement level that Medicare HMOs are getting relative to the average cost of fee-for-service beneficiaries?

We've heard numbers from 95 percent to 80 percent, which, you know, if we're talking about billions of dollars, is a huge difference—I mean, literally shooting in the middle of nowhere.

And it does seem to be a fundamental issue, that if we're talking about, you know, 95 percent reimbursement versus 80 percent reimbursement, you know, it is a totally different—I mean, again, you know, who—Dr. Moon or Ms. Ignagni or Mr. Powell, if anyone specifically can get at that, I mean, it just seems like such a significant issue that we're all over the map in terms of numbers we're hearing.

Ms. MOON. I think one of the important things to think about are what pieces of that differential you believe are indications of things that the managed care plans should be paid.

Two of them have been talked about, and I think that they are two of the important ones that you need to evaluate. The one is the issue of graduate medical education and the differential that that is involved there.

The question is whether or not the payments for graduate medical education should go to managed care plans, and then whether or not they're finding their way into graduate medical education.

And another difference is this issue of risk adjustment, which I think, as has been pointed out here, is highly controversial.

Ms. IGNAGNI. I don't see it that way. I have long and deep respect for Marilyn's work and would be happy to spend some time talking about the methodology. Graduate medical education was clearly backed out of the payment, No. 1, so health plans don't receive that.

In terms of the risk adjustor, from the CBO, everyone, in terms of looking at the legislative history, it was clear that that was intended to be budget neutral. Only HCFA seems to believe that it wasn't.

The fact is a cut is a cut.

Mr. Brown has made the point several times that he hasn't felt that we have done well enough in terms of explaining our methodology. We have been up here a number of times, but if it hasn't been enough I make a personal promise that we will bring up the actuaries, we will go through every aspect of the methodology.

What we have intended this is to provide you data that would be worthwhile data, would be honest data, and we could have a discussion, because from the beginning we thought that this was going to be bipartisan consideration and people would feel very concerned about the effects on their beneficiaries.

Mr. Green was probing with Dr. Berenson earlier about what was happening in your area. You will be interested to know that you are down at 75 percent of fee-for-service by 2004, and you have 28 percent of your beneficiaries, Medicare beneficiaries in Medicare+Choice. You can't run a program with that level of resources. You can't run the traditional program, let alone the additional benefits.

So we would be happy to do whatever it takes to satisfy Members that they have a chance to look at these numbers.

Mr. BILIRAKIS. Mr. Burr?

Mr. BURR. Thank you, Mr. Chairman. I don't even know where to start.

Let me just ask the whole panel: does anybody believe we will ever get this right?

[No response.]

Mr. BURR. I'll take that as a no from everybody. I share your answer.

Let me just make a reference, for purposes of the discussion you were just in, part of BBA 1997 was a phase-out of graduate medical education.

Ms. IGNAGNI. That's right.

Mr. BURR. And so that, I think, is on schedule. But in that set of BBA issues that were addressed in the CBO testimony in front of the Senate, it said those policies reduced the cumulative growth in Medicare+Choice rates relative to fee-for-service payments by 6 percent.

It went on to talk about the risk adjustor, and it basically says that the first stage of the risk adjustor would be based on the use of inpatient hospital services by individual enrollees. That change would reduce payments for existing enrollees by 7.6 percent when fully phased in by 2004.

The administration also announced a second stage of the risk adjustment that would be based on the use of services in all settings. The administration expects that such an adjustment would reduce payments by another 7.5 percent beginning in 2004.

If both plans are implemented as announced, the combined effect could reduce payments by 15 percent, plus 6 percent. My math tells me that's a 21 percent reduction based upon what is already in place.

So let me, if I could, just ask this question. What would entice a healthy person to enter a Medicare+Choice plan?

Ms. MOON. I believe that one of the things that beneficiaries have said over and over again, that the reason that they are initially attracted to those plans are the additional benefits that are being promised in these plans.

I think there is fundamentally, however, a misunderstanding by beneficiaries of whether or not this is a permanent promise in the same sense that the traditional benefits or the basic benefit package is promised.

Mr. BURR. What would be the attraction for a sick person?

Ms. IGNAGNI. Broader benefits.

Mr. BURR. Broader benefits?

Ms. IGNAGNI. Lower costs, catastrophic coverage.

Mr. BURR. No deductibles?

Ms. IGNAGNI. No deductibles, very limited co-pays.

Mr. BURR. Less out-of-pocket expense. I think the rabbi covered a number of them.

Aren't there, in fact, many more benefits——

Ms. IGNAGNI. Yes.

Mr. BURR. [continuing] for somebody who is sick——

Ms. IGNAGNI. Yes.

Mr. BURR. [continuing] than somebody that's well? I mean, when we look at private sector insurance, the well ones don't want anything to do with the system. They want to pay for it out of pocket because they don't feel that they're going to go to the doctor, they don't feel that they're going to be sick, they don't feel that they'll go to the hospital.

Seniors who are sick fear that they are going to go to the hospital, and they know—is it Canja?

Ms. CANJA. Canja.

Mr. BURR. [continuing] It is $760 out of pocket up front, isn't it? I mean, that's the Medicare deductible for hospitalization.

Ms. CANJA. That's the Medicare deductible. If they have Medigap, they are paying Medigap and they feel protected.

Mr. BURR. Do all of them have Medigap?

Ms. CANJA. I don't know the number, but I think many of them do.

Mr. BURR. But there's——

Ms. CANJA. They have fee-for-service.

Mr. BURR. [continuing] a pretty good share. So, in fact, the statement that everybody that is in managed care or Medicare+Choice is healthy is wrong. Does anybody dispute that? I mean, there are sick people in Medicare+Choice.

Let me ask you, Ms. Canja, because I think you alluded to it earlier, do you think that one of the core benefits of Medicare should be drug coverage?

Ms. CANJA. Definitely. We strongly believe that prescription drugs are part of modern medicine and really should be available to all Medicare beneficiaries.

Mr. BURR. Do you think it is fair to ask seniors in the country to make a premium payment for drug coverage with no stop-loss on it? In other words, in the President's proposal it says, "We'll pay 50 cents of every dollar from some point to $2,000, but if you have

over $2,000 a year in drug costs it is 100 percent you." Have you ever seen an insurance policy where at some point it became 100 percent the sick person?

Ms. CANJA. I just know all the people that are out there that don't have coverage right now, and it is 100 percent them right now, and they are paying.

You know, we hear the figure that 65 percent have prescription drug coverage now, but the truth is that they are very vulnerable and they have very little coverage.

Mr. BURR. I agree. We should supply a drug benefit, but my question, I guess to the panel, Should we take those individuals who have $2,000-plus in drug coverage and say, "After 2,000 you are on your own. It's out of your pocket," or should we provide them a policy that says, "At 2,000 we pick up 100 percent, not you"? I mean, aren't those the ones that are most at risk? Aren't those the ones that would be classified in that definition of sick? Wouldn't you agree?

Ms. MOON. Congressman, I agree with you, and I would much prefer to see a drug policy that had the stop-loss kinds of protections that you are talking about, but I would point out that the vast majority, for example, of drug benefits that are now available in managed care plans under Medicare have caps, and many of them lower than $2,000.

Mr. BURR. I think what all of you have made is really an impassioned argument about why we can do much better than we have today.

The rabbi is extremely pleased with his managed care coverage. I am, too. I've never had a problem with it.

We may live in exceptional parts of the country, we may have exceptional doctors, we may not have what everybody else has, but I believe that there are more people that are like you and me, and we're not the exceptions.

Clearly, we can do better in the structure, but there is one thing that I know that will stymie this—if we drive competition away.

The challenge for Congress, and I think for what every witness has suggested, is not less competition, it's more competition. It is to create a field—Mr. Bryant said it best. He said everybody is after a level playing field. Well, let me suggest to you that we've had a big discussion on risk adjustors today. Most of the people who testified to the Medicare Commission said risk adjustors are almost impossible to find a good one. That's what the Medicare Commission said. They suggested possibly a Medicare Board could help.

I'm hopeful that, as we move forward this calendar year, that not only can we solve the current problem but we can also address what the solution is to health care for seniors with a plan that makes sense, a plan that addresses the needs that are out there, a plan where we don't spend every 6 months questioning whether somebody is underpaid or overpaid, who cheats and who doesn't, but a plan where we have confidence that when we need it, it is there, and that we're getting the most bang for our buck.

I thank all of you for your willingness to come testify, and I yield back.

Mr. BILIRAKIS. I thank the gentleman.

I would only add to that that we're not going to get the job done or do a good job if we are not open-minded, if we have preconceived biases, and that has been some of the problems that we have had, unfortunately.

Mr. Green?

Mr. GREEN. Thank you, Mr. Chairman.

Mr. Powell, let me follow up on what my colleague from Ohio, Mr. Brown, talked about.

Do you agree with Dr. Moon's characterization of that $11.2 billion as not really a cut; it depends on if you treat people in your HMO that have an average, much better health than the others, than the general population, that 11.2 is not a cut, you have to actually earn that 11.2 to lose that money?

Mr. POWELL. No. The Seniors Coalition would not take that position. We would consider and we do consider the $11 billion a cut, and for precisely some of the reasons that Ms. Ignagni has spoken to, and that is the lack of—and this alludes to my testimony—the lack of outpatient care, primarily in the risk adjustor.

Mr. GREEN. Okay. But it is not a cut unless you—and you are disagreeing with the formula on outpatient, and I could agree that that formula should be in place earlier.

I know we received a lot of cards in our office, like a lot of folks, on the $11.2 billion cut, and we first looked to see what we're doing to Medicare and found out that it was a formula that HCFA is doing, you know, without that, and there is no act of this House that would actually cut 11.2 out of Medicare this year or next year or even the year after that. It is all in relation to the Balanced Budget Act.

Mr. POWELL. Yes.

Mr. GREEN. Okay. Ms. Moon, in your testimony you suggest that disruptions created by the plan withdrawal should not only be expected by accepted as part of the competitive process, and you also imply that Medicare HMO reimbursements have come more into line with the actual cost of caring for the enrollees. The extra benefits, such as prescription drugs, could likely be reduced, as well.

If this happens, what, if any, incentive will seniors have to elect a Medicare HMO? After all, under the current system a Medicare HMO appears to be a more-risky selection for a senior looking to receive both consistent and uninterrupted care.

Ms. MOON. I think you ask a very good question, because I think that it is a very difficult thing for someone who thinks of herself as a supporter of beneficiaries to be sitting in front of you and saying, "Maybe we should think about something that is going to eliminate some benefits that they receive."

My biggest concern is a fairness issue between what is available to people in fee-for-service and what is available to people in managed care plans and whether it comes out because of overpayment.

If managed care plans could be paid what these folks would cost in fee-for-service and achieve other savings, then I wouldn't have a problem.

I think the reason that people might still choose managed care is that there are people out there who like that arrangement, who find it extremely desirable, as the rabbi talked about, and, in exchange, they get and should expect to get, I believe, big reductions

in deductibles and cost sharing, because that's really the tradeoff. The issue is you're agreeing to let the managed care plan put some additional controls on you in terms of who you visit and how you get care in exchange for the lower deductibles and cost sharing, and that seems to me that's the most important tradeoff you've got to make sure is there.

The extra benefits are attractions to beneficiaries, and the question is whether or not they are being financed by overpayments, and I think that's a very hard issue to deal with.

Mr. GREEN. Thank you.

For everybody on the panel—and I know, since you mentioned Houston area, we have an unusual situation where a lot of our HMOs are actually merging in taking market and trading market, almost like Time Warner did with TCI. They traded the Houston market for the Dallas market so they could consolidate, and that's what is happening in Houston. In fact, I think there is a question of one of the mergers, the number of mergers now is 65 percent of Medicare HMOs will be under one company, and there was a question about that.

The 70,000 that we talk about in the testimony that will not have access to an HMO, do we have a breakdown on rural/urban for that 70,000? Do you know off the top of your head? Is it equally applied in rural and urban areas? Is it more likely in rural areas?

Ms. IGNAGNI. I know you're not going to believe this—with all of the material that we brought, we didn't bring that chart. We looked at so many counties around the country. In fact, I was just in Houston on Monday with a group of beneficiaries who are very, very concerned about what may happen if this problem isn't addressed. But we would be delighted to get back to you this afternoon. I'm sorry I didn't bring that chart.

Mr. GREEN. Thank you, Mr. Chairman.

Are we going to have a second round?

Mr. BILIRAKIS. Preferably not, but, I mean, if the 4 or 5 of us left here——

Mr. GREEN. I have one more question.

Mr. BILIRAKIS. One more question.

Mr. GREEN. Mr. Chairman, I appreciate the chance to ask this, because I know this is—it's related to HMOs, and, in fact, I almost wish Dr. Colburn was here.

Ms. Ignagni, last week I saw an article in the "Washington Post" that talked about a certain health care provision that—let's see, Dr. Colburn was quoted in here about he knew of an obstetrician in Muskogee who is exposed to—his patient was exposed to chicken pox virus, and the doctor prescribed a $700 injection for antiserum, but the insurance company refused, even though she had obstetric care.

Your quote in here was that, for example, "They didn't say so directly, they implied that the doctor's personal experience had been skewed in views of the industry." And you say that the real problem is that the employer didn't buy a plan that approved of that particular treatment.

Believe me, you have some sympathetic folks up here who realize the press takes one statement out of context, but in my experience in my earlier life as a business manager and shopping for insur-

ance for a company, I never got into whether they gave a shot for something or not. It was obviously we were shopping for the best deal for my employees and for the company.

Do you know of anybody that would know you didn't have this shot that was medically necessary?

Ms. IGNAGNI. Actually, there's a whole range of issues subsumed in your question. I'll deal with it as directly as I can.

As you know, employers make decisions about whether they are going to buy particular riders, experimental procedures, and more increasingly now for particular pharmaceutical and prescription therapies that's in the premium or outside, you buy it, etc.

I think that one of the points that I was making to that reporter—and I appreciate what you've observed—I think, you know, oftentimes people reduce to lowest common denominator a particular point. That the issue of medical necessity is far more complicated than really the discussions would suggest, and I think that we have to back up and look more broadly at where first-level decisions about coverage are made, how they are made, why they are made, and then where do we go from there in terms of medical necessity, and then bringing in information with respect to clinical trials and best practice and matching that with physician recommendations.

It was a very long discussion that got distilled to two lines, I think.

Mr. GREEN. I guess what bothers me in the umbrella debate on managed care that Medicare is just a part of, that to say that an employer refused to buy a certain benefit for, you know, for a chicken pox virus that a child or a mother was exposed to, I think that was a bad rap on employers, because I have yet to have experience with an employer who had that specificity on some type of thing.

Again, I understand newspaper articles aren't always factual, and that's what bothered me in the umbrella debate.

Ms. IGNAGNI. And I appreciate what you say and your point is very well taken.

I was just going to say, Mr. Chairman——

Mr. BILIRAKIS. Very briefly.

Ms. IGNAGNI. [continuing] that we were talking for a good deal of time about how first-order decisions are made and where they are made. The reporter thought that health plans were making all of these decisions, so I was endeavoring to back up and talk about what the purchaser does, what that role is, what the health plan role is, what the physician role is, and how it all comes together.

I see by your reaction that I probably did a miserable job at it, so I appreciate your admonition.

Mr. BILIRAKIS. Mr. Barrett?

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BARRETT. Thank you, Mr. Chairman.

One of the disadvantages or advantages of being last is you get a lot of time to think about things.

I'm thinking about what is going on right now in the Ways and Means Committee, and the negotiators have just reached this agreement on the $792 billion tax cut. We're doing the appropriations bills. And, as I just left, the subcommittee Chair was talking about how austere it was.

Mr. Powell, I associate with the Seniors Coalition being closely allied, frankly, with the republican party.

Mr. POWELL. We're nonpartisan on——

Mr. BARRETT. I understand. I understand. And AARP is not partisan and they're not associated with democrats. I understand how both of those work.

Where is this $11.2 billion coming from again?

Mr. POWELL. From our understanding, the $11.2 billion——

Mr. BARRETT. No. You're saying it is a cut. I'm accepting it. How do we make it up?

Mr. POWELL. Well, I think the first thing we do is examine the chairman's bill, No. 1, which would bring into budget neutrality the risk adjustment.

Mr. BARRETT. Very good, $11.2 billion we just spent. And if we pass this bill and there is no longer an $11.2 billion cut, it is revenue neutral, we just raised spending $11.2 billion.

Mr. POWELL. We maintain projected spending.

Mr. BARRETT. Okay. But if there is a $11.2 billion cut and we get rid of that, that means we're getting $11.2 billion from somewhere. I'm just thinking a little mathematically here. Are you with me?

Mr. POWELL. Yes.

Mr. BARRETT. Okay. So I'm accepting the cut.

Mr. POWELL. Okay.

Mr. BARRETT. Are you saying we should cut other programs?

Mr. POWELL. I don't think it is an either/or decision.

Mr. BARRETT. What are you talking about? If you're saying there's an $11.2 billion cut, we either raise taxes, cut other programs, or add to the deficit. Take your pick.

Mr. POWELL. Well, those are three very sad choices, and I——

Mr. BARRETT. I know, but you're the one saying there is a cut, and I'm just asking you, if we want to address your problem, help me. Which one should we do?

Mr. POWELL. If we were to look at what we see as a projected cut through the risk adjustor and the Medicare program, it is merely that at this point.

Mr. BARRETT. I'm accepting that. You said it was a cut. You said to Mr. Green it's a cut. I'm accepting that.

Mr. POWELL. Yes.

Mr. BARRETT. I'm just asking a simple question—deficit spending, other cuts in other programs, or tax increase.

Mr. POWELL. Well, we're going to oppose any kind of tax—point well made.

Mr. BARRETT. Okay. And I have to say, Ms. Ignagni, I respect you, I listened to you, and I thought back to a conversation I had with a hospital in my District, hospital administrator, and, as all of us know, you're not the first ones in the line here—nursing homes, occupational therapy, physical therapy, home health care, outpatient services, inpatient services, you name it.

And, as I tell all of them, there's more to come. We're paying for this beautiful tax cut. There is more to come.

But, as I was talking to the hospital administrator, he was telling me how bad the Medicare reimbursement rates were, and he said, "You know, it's almost getting as low as HMO." And I nodded my head. And I said, "Let me make sure I understand this. You're

saying that Medicare pays more than HMO?" And he said, "That's right."

My question to you: are we overpaying the hospital?

Ms. IGNAGNI. I don't know.

Mr. BARRETT. Are we subsidizing—if it is a competition market and HMOs are paying less than Medicare, shouldn't Medicare be reducing its payments to come in line with HMOs, or are we subsidizing you?

Ms. IGNAGNI. I think what we've done in our delivery system on the fee-for-service side is that fee-for-service hasn't put in play the types of forces that managed care has. We've driven consolidation in some parts, and if the entire delivery system were a competitive one we would have far more and far fewer hospitals and hospital beds, particularly unused hospital beds, than we have now. We'd have a different distribution of physicians, etc.

So in many ways the traditional program, because of its fee-for-service nature, subsidizes inefficiency where there is inefficiency.

But, having said that, that's in the eye of the beholder. I've also been in some communities, even though there have been three hospitals there, they fought very passionately to keep the third hospital, so I understand precisely what you're saying.

I think it is very hard to sort through all of this. We're not testifying before you today to say, "Help us at the expense of everyone else."

Mr. BARRETT. I understand that.

Ms. IGNAGNI. Other aspects, other entities within the delivery system have made rational and real observations about the effects of BBA. What I would say to you is that I think that there is compelling reason to "T" up this as an issue this fall, take action now before we have more of the kinds of effects you're——

Mr. BARRETT. But you're also sophisticated enough to know, again, that you're not the only one standing in this line.

Ms. IGNAGNI. Precisely, and I'm not going to run down the other guys, either.

Mr. BARRETT. But my point is that if we're going to throw $11.2 billion back into the HMOs and I go back to the hospitals and say, "The money is gone," and he's saying, "Well, wait a minute," the reality is that—and this was his complaint. His complaint was that there's not enough money in Medicare reimbursement to continue the subsidy of HMO payments, which blew my mind that somehow Medicare is supposed to subsidize HMO payments because HMO payments are too low.

If I could have just a minute, Mr. Chairman, as well—the whole issue of drug coverage—I just have to touch on that very quickly. Ms. Moon, I'll ask you, because I've heard, again, some of my colleagues here in Congress say, "Well, there's no problem here. Two-thirds of the American people have drug coverage." I think both Mr. Armey and Mr. DeLay I think we've seen on television saying, "We don't have to expand Medicare coverage of drugs."

From your perspective, how solid is this drug coverage?

Ms. MOON. From my perspective, I think that we're talking much more about a base of about 40 percent of the people having pretty good prescription drug coverage, the bulk of those people being folks who have good employer-based coverage and the folks who

have Medicaid. So Medicaid is already a public expenditure, and if you replace Medicare with Medicaid, there would, to some extent, just be a tradeoff.

So I think that it is much thinner than people talk about, both in terms of the extensiveness of the coverage and what is happening in terms of things like affordability of Medigap coverage to people who buy prescription drug benefits.

And, as I indicated before, the caps in HMO plans are often substantially tougher than the caps that were in the administration's proposal.

Mr. BARRETT. Thank you.

Mr. Chairman, I would just ask unanimous consent that—I have a document here on the President's health care, his Medicare plan prescription coverage.

Mr. BILIRAKIS. Without objection.

Mr. BARRETT. Thank you.

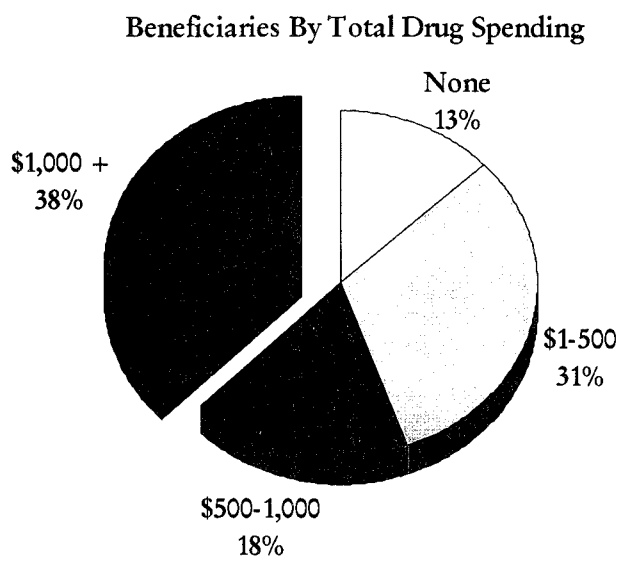
[The information referred to follows:]

DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

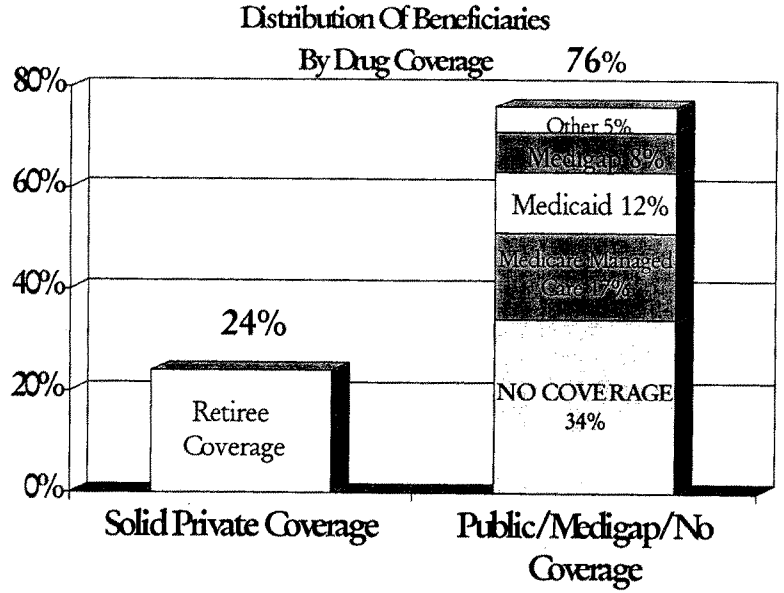
July, 1999

Medicare Beneficiaries Need Prescription Drugs



SOURCE: Actuarial Research Corporation for HHS, 2000

Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



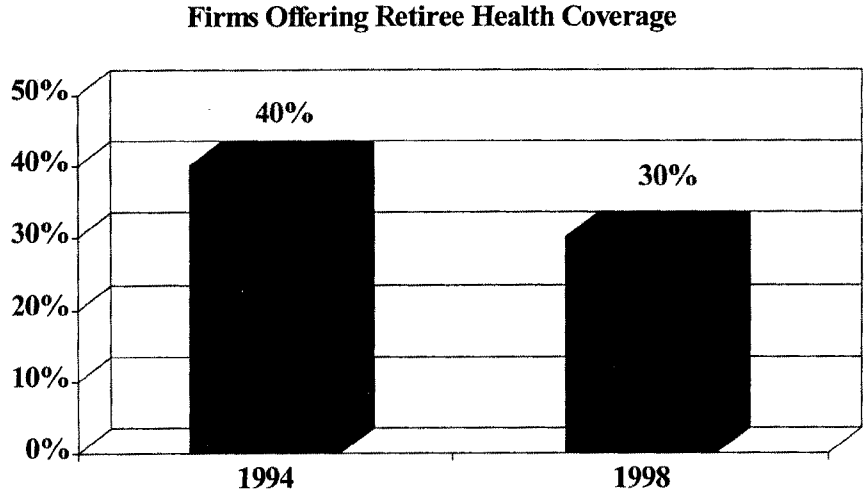
SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

PRIVATE DRUG COVERAGE:

Unstable and Declining

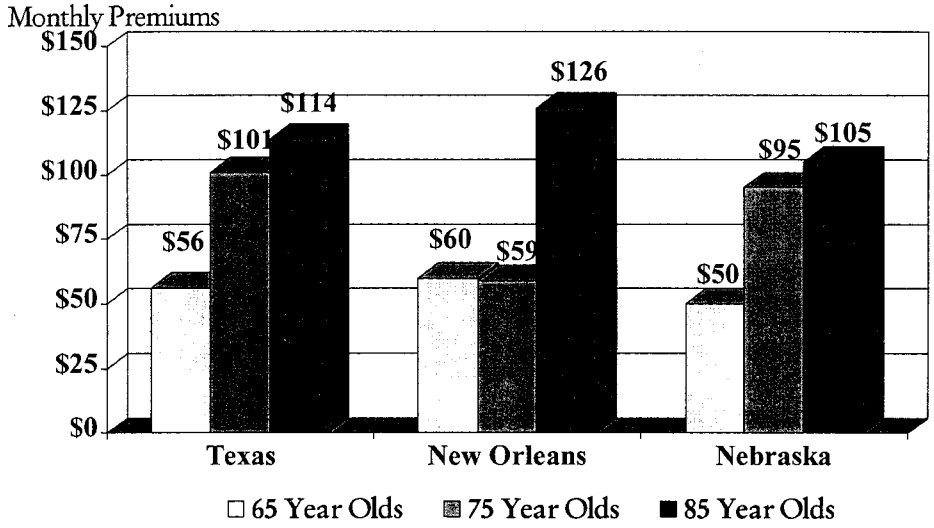
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

Medigap Premiums For Drugs Are High And Increase With Age, 1999



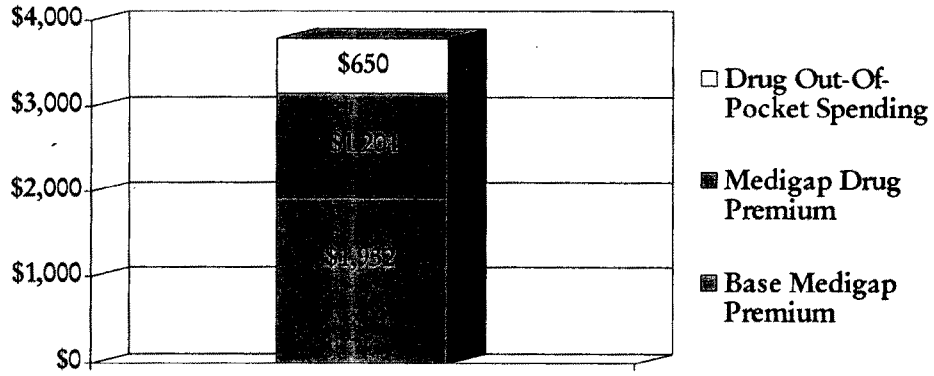
Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

when you need it the most you have to pay the highest.

Beneficiaries With Medigap Still Pay High Out-Of-Pocket Drug Costs

On Top Of The Premium For The Base Medigap, Beneficiaries Pay An Extra Premium For Drugs Plus Out-Of-Pocket Spending for Drugs

Medigap Annual Premiums And Out-Of-Pocket Spending

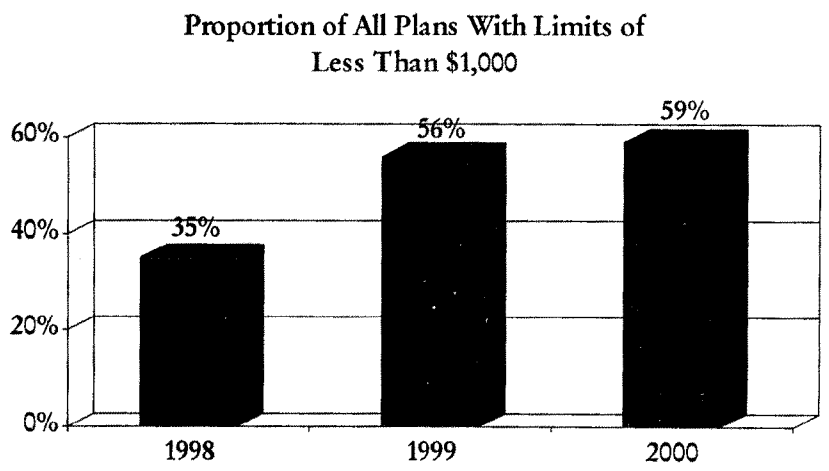


SOURCE: Actuarial Research Corporation for HHS. Premium from Texas for a 75 year old: base is $161 per month; drug addition is $101 per month

PUBLIC COVERAGE FOR PRESCRIPTION DRUGS

Value of Medicare Managed Care Drug Benefits Is Declining

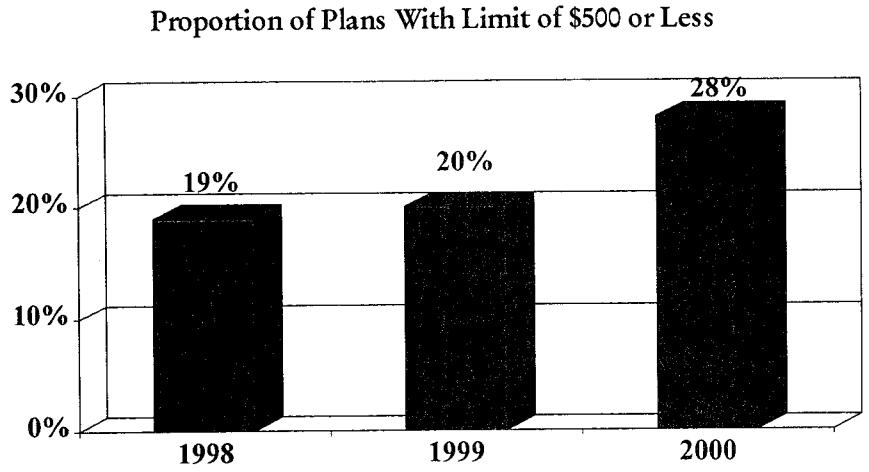
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Limits on Medicare Managed Care Drug Benefit Are Getting Lower

Proportion Of Plans With A $500 Or Lower Limit Has Increased By 50%

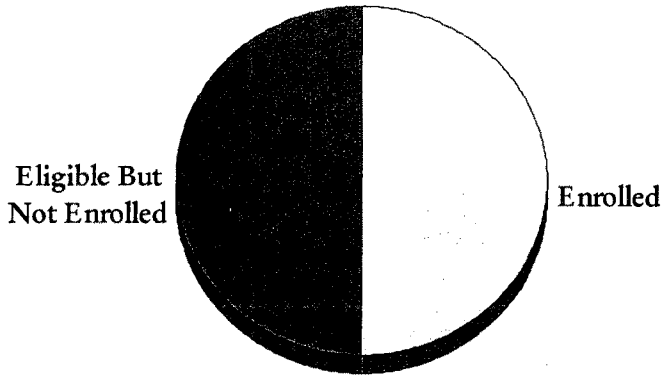


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Participation In Medicaid Is Low

Only 50% Of Eligible Beneficiaries Are Enrolled in Medicaid

Eligible Medicare Beneficiaries' Enrollment in Medicaid



SOURCE: Actuarial Research Corporation for HHS. Calculated assuming that beneficiaries below 73% of poverty are eligible for full Medicaid benefits through SSI (Kaiser Commission on Medicaid & the Uninsured, May 1999)

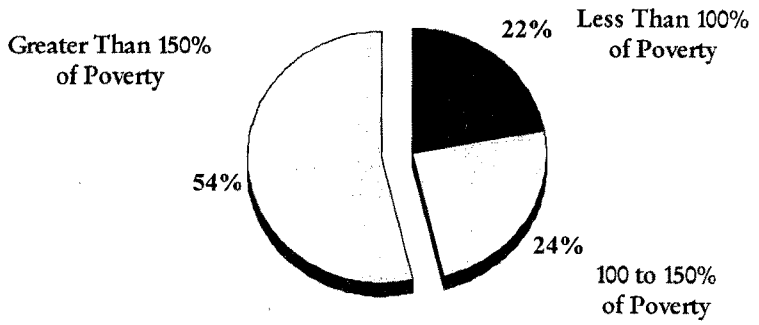
MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE

At Least 13 Million Medicare Beneficiaries Lack Prescription Drug Coverage

Many Uninsured In Middle Class

Over Half of Medicare Beneficiaries Who Lack Prescription Drug Coverage Are In The Middle Class

Income of Beneficiaries Without Drug Coverage
(As A Percent Of Poverty)

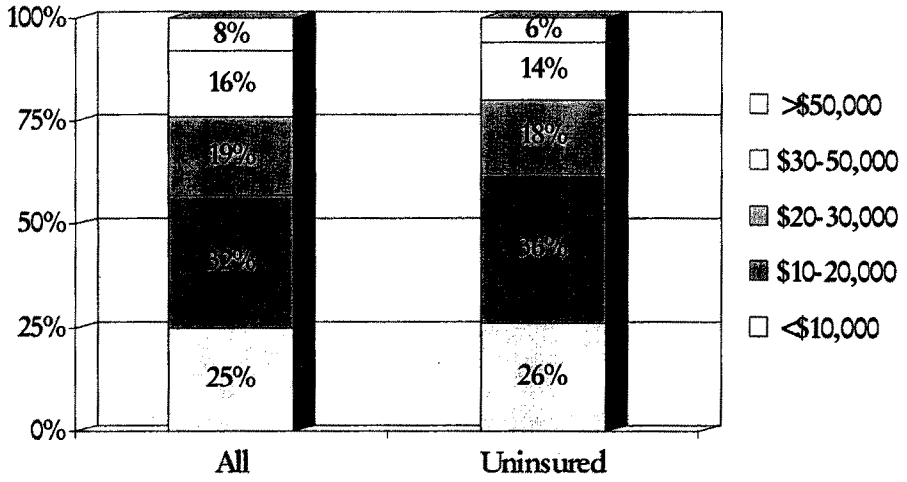


SOURCE: Actuarial Research Corporation for HHS, 2000
In 2000, poverty for a single person is about $8,500, for a couple is about $11,400

undermines argument that just need to protect poor

Lack of Insurance Affects All Medicare Beneficiaries

Income of Beneficiaries Lacking Coverage Matches That Of All Beneficiaries

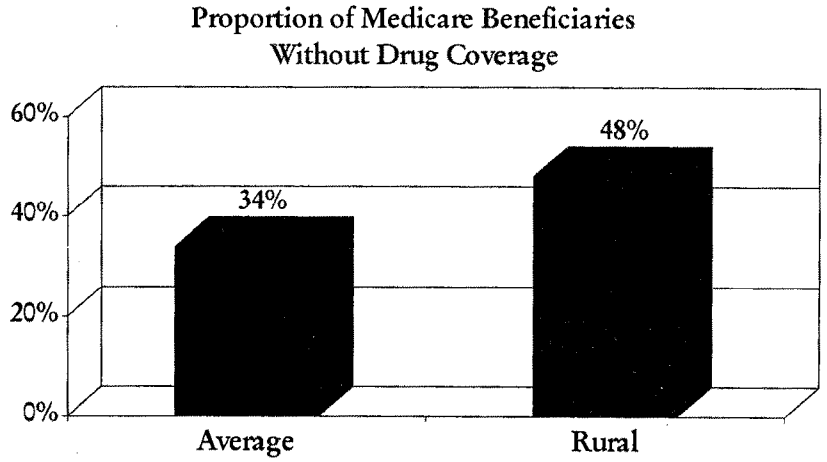


SOURCE: Actuarial Research Corporation for HHS, 2000

- problem all up and down the income scale

Fewer Rural Beneficiaries Have Drug Coverage

About Half of All Rural Beneficiaries Lack Drug Coverage --
Rural Beneficiaries Comprise One in Three Uninsured Beneficiaries



SOURCE: Actuarial Research Corporation for HHS, 2000

1/3 WHly
1/2 in rural area

Methodology

The Actuarial Research Corporation under contract with the Department of Health and Human Services conducted most of the analysis. The basis for the estimates is the Medicare Current Beneficiary Survey (MCBS) for 1995. These data were aged to CY 2000, converted to a point-in-time estimate, and adjusted for the increase in managed care enrollment. This enrollment increase was estimated by moving beneficiaries from retiree health coverage, Medigap and the uninsured to managed care in proportion to their enrollment in those plans.

Mr. BILIRAKIS. Mr. Brown would like to——

Mr. BROWN. Mr. Chairman, I just want to make a comment. I was a little confused. I've heard during this hearing that managed care companies are only going to experience a 2 percent increase next year, and I was looking through Dr. Berenson's testimony. He said under the BBA system a rate for a particular county is the greater of three possible rates—a new minimum or floor payment, a minimum 2 percent increase over the previous year's rate, or a blend of the county rate and an input price adjusted national rate.

Now, we had heard that the amount was only going to go up 2 percent next year. Well, 2 percent is the absolute minimum for any managed care plan.

He then goes on—and I'll conclude quickly, Mr. Chairman—in his testimony, "Payment is rising in all counties this coming year by an average of 5 percent, and in some areas will rise by as much as 18 percent—" payment to managed care companies.

"The BBA payment reforms were designed to increase payment in counties that had the lowest rates and therefore the fewest number of plans, yet counties—" and this is perhaps the most important part "yet counties receiving the largest increase under the BBA system are experiencing the most disruption, dropping the most beneficiaries."

Plan withdrawals are affecting 11 percent of enrollees in counties where rates are rising by 10 percent, the highest, 11 percent withdrawals there, but affecting only 2 percent of enrollees where rates are rising by just 2 percent.

So it is hard to sort of juxtapose that and understand, when some people here have claimed that the increase is only 2 percent. It's 5 percent average, as much as 18 some places, and that's not really what is causing the dropping, the withdrawing of plans.

Mr. BILIRAKIS. Why don't we finish up with a response from Ms. Ignagni regarding that.

Ms. IGNAGNI. And I'll be very quick, Mr. Chairman.

Mr. Brown, HCFA has often observed and made the case this isn't a pervasive problem because the rate of increase, on average—frequently the qualifier "on average" is not inserted in either testimony or observations.

Here's what's wrong with that. Of the beneficiaries, 78 percent now are in counties that are going to get less than 4 percent. And I said to you earlier in my oral statement that 38 percent of the beneficiaries are in counties that are going to get 2 percent. There is only one county in the United States that would get 18 percent—it's actually 17.8 percent—and there are no Medicare risk enrollees living there. In fact, there are only 208 beneficiaries overall.

We have a run of——

Mr. BILIRAKIS. Dr. Berenson didn't tell us the truth?

Ms. IGNAGNI. I think that Dr. Berenson probably was looking at the broad issue of 5 percent, which is the average of where you begin. It's 5.8 in the traditional system. It gets down to 5 is where the starting point is on the Medicare+Choice side, and then all those things are backed out—GME, all of the issues that we've talked about come into effect, then you add the risk adjuster, you add the user fee, so in some counties you are down at the levels we talked about, and it may actually be interesting for the commit-

tee to note that in some counties now we are going to be down below 1 percent in some areas because of the risk adjustor and the user fee, etc.

So we have a real problem here, and I think that it is important to look very clearly not just at the gross data but where it filters out on a county-by-county basis and where we have the individuals grouped in those counties.

Mr. BROWN. Before asking Dr. Moon to also reply to that, I think this committee or this subcommittee was led to believe 2 percent was the average, and now we are acknowledging it isn't, it's the absolute floor but the average is 5. So if you're talking about averages earlier, now you don't seem too much——

Ms. IGNAGNI. I didn't make the observation. I believe I was the primary one to talk about numbers, because we seem to be one of the few groups that has them. I never made the observation that 2 percent was the average. In fact, I remember stating in my oral statement that 38 percent was in 2 percent, that 78 percent was under 4 percent.

I apologize if you drew an erroneous conclusion from something I said.

Mr. BROWN. Well, I think other people up here——

Ms. IGNAGNI. I didn't mean to——

Mr. BROWN. Okay. I accept that. But I think other people up here, when we made the contrast between 2 and that fee-for-service was getting 5——

Ms. IGNAGNI. I think that was in response to Mr. Deutsch's comment, and, indeed, in his counties many—we were having a discussion at that time, and perhaps that was when you perhaps drew an erroneous conclusion from something I said. And if it was based on something I said, I apologize.

We have endeavored to work very, very hard to provide fair and accurate numbers, and I make you a personal promise that we would be happy to talk about these numbers in whatever detail you, your staff, or anyone else wants to see.

Mr. BILIRAKIS. And, of course, you're all available for any questions that may come in writing to you.

Ms. IGNAGNI. Yes, sir.

Mr. BILIRAKIS. Did you want Dr. Moon——

Mr. BROWN. If Dr. Moon would respond.

Mr. BILIRAKIS. Very briefly respond so that we can finish up here.

Ms. MOON. I would just like to reiterate that I think that it is very important to look not only at the rates of growth in 1 year but over a period of time. We had very high rates of growth for a long time in which the base was built up, and I think that's an important thing to think about, as well as the issue that there are a lot of reasons why plans withdraw, and only one of them is the issue of payment.

Mr. BROWN. And last, Mr. Chairman, the impression was still left with this committee, advertently or inadvertently, from comments on both sides of the aisle, from Mr. Burr and Mr. Deutsch to me, that managed care was getting squeezed while fee-for-service was going to get so much more money. That was really the im-

pression left, unless I totally misread it, but from several people on this panel today.

Ms. IGNAGNI. In fact, though, if you look at where the beneficiaries are living and you compare it to what is happening on the fee-for-service side for next year, you make a very strong observation about the disadvantages, and that's what the providers are saying.

Given the rates of increase, in addition to all of the additional administrative obligations—it's not just health plans, but providers observing that—I think they're making honest and legitimate points.

Mr. BROWN. Should we believe those same providers in their observations about the quality of managed care?

Ms. IGNAGNI. I think that providers actually have quite a lot to offer this discussion about managed care, and I think that quite a lot also is talked about in terms of quality that are quite appropriate by way of denials, and we just have to separate the two.

I'd be delighted to come back and talk about that.

Mr. BILIRAKIS. Again, we need to be objective and open-minded. Talking about the 2 percent, I wrote a couple letters to a couple of the plans that were dropping people in my Congressional District, and I received a response from one today. It says, "As you are aware, since the passage of the Balanced Budget Act 1997, our reimbursement has increased at an approximate rate of only 2 percent per year." And then, in parenthesis, "less the user fee, the cost of regulatory compliance, and beginning in 2000 risk adjustment. At the same time it has seen combined pharmacy, hospital, and physician cost trends increase in the range of 5 to 6 percent," etc., etc. So we are getting that sort of thing, and I don't know whether that 2 percent is accurate, but that's basically what we're hearing.

I think Mr. Brown's point is well taken in terms of perception.

Listen, it has been a heck of a hearing. Thanks so very much for your contribution. You've helped an awful lot.

The hearing is adjourned.

[Whereupon, at 2:48 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[Additional material submitted for the record follows:]

HUMANA INC.
LOUISVILLE, KY
August 2, 1999

The Hon. MICHAEL BILIRAKIS
Chairman, Health & Environment Subcommittee
House Commerce Committee
2369 Rayburn House Office Building
Washington, D.C. 20515

DEAR CONGRESSMAN BILIRAKIS: Thank you for the opportunity to share the process Humana used in reaching our decision to reduce our Medicare+Choice service areas for the year 2000.

First, let me assure you that we did not take this process or decision lightly. As one of the largest and oldest Medicare+Choice plans in the country, we are strongly committed to the program and, more importantly, to Medicare beneficiaries. Because of this commitment, our bias throughout our evaluation process was to try to find a way to remain in a market if at all possible.

With that background, let me describe the process we used to analyze our opportunities in the 89 counties in which we currently offer a Medicare+Choice plan. We began by developing a profile of each county. That profile included:

- *Current and projected HCFA reimbursement*. We factored in both HCFA's published payment increases for 2000 and projected risk adjustment reductions based on the limited data HCFA has released to date relative to the payment methodology they will be employing starting in 2000.
- *Provider dynamics in each market.* We assessed providers' level to provide high quality care while managing costs within the parameters of the available funding.
- *Current and projected costs of providing M+C benefit plans in light of medical cost trend.* We track medical costs monthly by county. We then projected our costs going forward using current and projected future medical cost trends, including medical inflation and increased utilization of services.
- *Competitive dynamics in each county*. We assessed the relative strengths and management capabilities of our provider networks; and the likelihood that our competitors would similarly respond in this high, Medicare cost and artificially low reimbursement environment.

As you are aware, since the passage of the Balanced Budget Act in 1997, our *reimbursement has increased at an approximate rate of only 2% per year* (less the user fee, the cost of regulatory compliance and beginning in 2000, risk adjustment). At the same time, we have seen combined pharmacy, hospital, and physician *cost trends increase in the range of 5%-6%.* Using this data, we evaluated certain options: 1) offering the same level of benefits at the same or increased out-of-pocket beneficiary costs (premium and copayments); 2) reducing benefits and offering the plan at the same or increased out-of-pocket costs; 3) reducing benefits and increasing out-of-pocket costs; and 4) non-renewing the plan or exiting the county. We then overlaid these changes on our ability to retain current members and attract new members. The findings of this analysis led us to regretfully discontinue offering Medicare+Choice plans in 31 of the 89 counties we serve today.

Non-renewing our Medicare+Choice contracts in 31 counties was but one of the changes we made in our Medicare+Choice program for the year 2000. We also filed proposed benefit, premium and out-of-pocket cost changes in most of the remaining 58 counties. *On average,* beneficiaries will see benefit reductions worth $6.86 per member per month and a premium increase of $13.98. On average, these changes may not appear to be severe, but at an individual plan level, they will have impact. Below is an illustration of the impact of the growing reimbursement gap:

- *Currently, we offer a total of 25 plans in 20 markets or 89 counties.*
  - 18 plans have a zero member premium and pharmacy, preventive care, and ancillary benefits. Currently 89.3% of our membership are enrolled in these ancillary plans.
  - 7 plans have a member premium ranging from a low of $10 per member per month to a high of $75 and, while these plans generally have an enhanced pharmacy benefit, only 10.7% of our membership are currently enrolled in these plans.
- *In 2000, we will offer 24 total plans in 15 markets or 58 counties.*
  - 3 plans, as filed, have a zero member premium and essentially the same benefits as in 1999. These 3 plans are projected to only cover 32.9% of our expected year 2000 membership.
  - 4 plans, as filed, have a zero member premium, but significant benefit reductions ranging from a low of $8.39 per member per month to a high of $39.26. These 4 plans are projected to only cover 12.7% of our expected year 2000 membership.
  - 17 plans, as filed, have both a member premium and moderate to significant benefit reductions. The premiums, as filed, range from a low of $10 to a high of $130 per member per month. The benefit reductions, as filed, will range from a low of $2.57 to a high of $46.78. These 17 plans are projected to cover 54.4% of our expected year 2000 membership.

It is important to note that despite these major changes for 2000, a number of the 58 counties remaining in our service area will produce breakeven results at best, provided we meet our expectations on enrollment and maintain effective provider contracts.

Annually, we evaluate each of our plans. Future cost and reimbursement trends and/or any new coverage, benefit or access mandates enacted by Congress or the states or unnecessary and costly government regulatory burdens only increase the likelihood of similar action next year.

Given our long commitment to the Medicare program, we certainly would prefer to avoid future exits and are trying to work with Congress and the Administration to find a mutually satisfactory solution to the current situation. I trust that the

above information meets your needs. If I can be of further assistance, please do not hesitate to contact me.

Respectfully yours,

HEIDI MARGULIS
Vice President, Government Affairs

RESPONSES FOR THE RECORD OF ROBERT A. BERENSON, DIRECTOR, CENTER FOR HEALTH PLANS AND PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION

QUESTIONS OF HON. TOM BLILEY

Question 1. Do physicians have to do the same kind of quality reporting under Medicare fee-for-service that they have to report to the plans to comply with QISMC? Is it possible this is another disincentive for them to participate in Medicare+Choice?

Answer 1. Our goal is to require physicians to have quality reporting in Medicare fee-for-service similar to what is being done for Medicare+Choice. We are exploring potential methods for requiring data regarding specific performance levels from fee-for-service providers. For example, We are currently requiring Medicare home health agencies and nursing homes to collect and submit uniform performance measurement data. We collect data on hospital performance and are considering requiring hospitals to collect and submit such data as part of the new conditions of participation. We are also writing performance-based contracts with our Peer Review Organizations to improve Statewide performance in fee-for-service and managed care. Under all of the revised conditions of participation that are now in various stages of development for various fee-for-service provider groups (hospitals, home health agencies, dialysis facilities, hospices), we will require performance improvement activities resulting in measurable improvement. With most of these provider groups, either the draft conditions or other arrangements require the providers to participate in national efforts similar to those required in QISMC.

Question 2. Doesn't the risk adjuster score as healthy someone with a chronic disease who may be getting a lot of outpatient care but who hasn't been hospitalized recently? For example, a stage 4 (metastatic) breast cancer patient who has gone through two rounds of chemotherapy and a round of radiation therapy but who hasn't been hospitalized in 5 years would be very expensive, but the plan would get much less money for that person than it would have if the person had stayed two nights in a hospital.

Answer 2. We assume that plans will do what is in the beneficiaries' best interest and not manipulate care simply to "game the system." Nevertheless, patients with chronic conditions, such as metastatic cancer treated primarily on an outpatient basis, are still hospitalized at a higher rate than those who are not chronically ill. Plans continue to have incentives to manage care on an outpatient basis because of the high direct costs associated with hospitalization and the fact that the additional risk adjusted payment will not be made until the following year, at which time the beneficiary might not still be in the plan. In addition, the PIP-DCG model does not, as alleged, reward plans for increased hospital days. Changing medical management practices to include hospitalizations would be a financial loser for plans. We are committed to moving as soon as possible to a comprehensive risk adjuster that fully accounts for patients with chronic conditions, rather than the PIP-DCG model which only partly accounts for the costs associated with certain chronic conditions. In the meantime, we are working with plans to make adjustments to the PIP-DCG model for conditions that are specifically amenable to sophisticated disease management approaches, such as congestive heart failure.

QUESTIONS OF HON. MICHAEL BILIRAKIS

Question 1. I am concerned not only with the budget implications of the risk adjustment mechanism, but also with the methodology involved. There are several programs which serve the frail elderly population. The purpose of these programs is to keep these at-risk individuals out of the hospital. How are these programs treated and effected by the proposed risk adjustor?

Answer 1. We share concerns about how these types of programs, which have a special focus on keeping the frail elderly out of hospitals, will fare under our initial risk adjustment system based on hospitalization diagnoses.

We therefore will not apply the risk adjustment method in determining their payments in 2000. We also are working with these organizations to get the encounter data we need to determine how we should risk adjust their payments. For example, some kind of special frailty adjuster may be in order.

Question 2. It has been estimated that the risk adjustor proposed by HCFA will save roughly $11.2 billion. Can you explain, in detail, where these savings would come from and where the savings would go (e.g., U.S. Treasury, Medicare Trust Fund, etc.)?

Answer 2. The new risk adjustment methodology more accurately determines payments for managed care enrollees than the current methodology, which is based on demographic factors only. The new risk adjustment methodology considers health status as well as demographic factors in determining payments. Payments will be higher for sicker than average enrollees and lower for healthier than average enrollees. Many studies have shown that managed care enrollees are healthier than average. Therefore, on average, payments to managed care organizations will be lower under the new methodology than the current demographic only model. Since all benefit payments for Medicare enrollees are made from the Medicare trust funds, any savings due to making more accurate payments would be savings to the trust funds.

Question 3. It is my understanding that many seniors participate in the Medicare+Choice program to obtain the prescription drug benefits available through Medicare managed care plans. However, HCFA's methodologies generally assume that Medicare+Choice participants are healthier than individuals in traditional, fee-for-service Medicare. Do you have any information comparing the prescription drug utilization rates for Medicare+Choice participants versus those for beneficiaries who do not participate in the program?

Answer 3. We do not have sufficient information to do such a comparison. Because prescription drugs are generally not covered under Medicare, we would not have utilization information for Medicare fee-for-service beneficiaries. For Medicare+Choice enrollees, we do not collect information on drug utilization.

QUESTIONS OF HON. SHERROD BROWN

Keeping Up with the Private Sector

Question 1. During the hearing, I asked whether the government fee-for-service program is able to keep up with private sector health care plans. Dr. Berenson, you indicated that risk adjustment helps the fee-for-service program keep pace with private managed care organizations, but you added that there are several other things that we need to do. Would you please elaborate on those other steps?

Answer 1. There are a number of steps proposed in the President's Medicare reform proposal to make Medicare a more "prudent purchaser." Historically, traditional Medicare generally (except in the context of demonstrations) has been barred from engaging in competitive bidding and other "prudent purchasing" practices that the private sector has used to improve patient care quality and costs.

In the past decade, private purchasers of health care have developed effective techniques that target both beneficiaries with special health care needs (recognizing that they account for a large share of costs and could benefit from care management) and high-quality, efficient providers (to provide an incentive to improve care and reduce costs). Such practices include: reducing beneficiary cost sharing in return for using high quality/cost-effective providers; improving and coordinating care for beneficiaries through management of specific diseases and/or all of beneficiaries' care; and purchasing through competition, selective contracting, and negotiated payment rates.

Under the President's plan, traditional Medicare would be able to establish preferred provider arrangements, with special rates and discounted beneficiary copayments for the highest quality and most efficient health care providers. We have had some experience with these types of purchasing techniques including the "Centers of Excellence" demonstration project for coronary artery bypass graft surgery in which we recognize exceptional quality providers while at the same time reducing costs. The President's plan would allow Medicare to make a single payment for certain procedures or conditions, provide incentives for qualified integrated delivery arrangements, and develop innovative pricing arrangements, for example, through competition, to promote quality and savings, as is commonly done in the private sector. In addition, similar to successful private sector efforts, fee-for-service Medicare should be able to utilize primary care case managers and disease management strategies to improve the care for Medicare beneficiaries with multiple chronic health conditions and complex health care needs to help make sure they get the care they need while avoiding unnecessary services.

Overpayments to Medicare+Choice Plans

Question 2. In the Balanced Budget Act, we made a number of changes to the way health plans are compensated in an attempt to correct overpayments to Medicare+Choice plans. However, a June 1999 report from the General Accounting

Office (GAO) found that even with those changes, we still may not completely eliminate overpayments to health plans. Would you please comment on this study?

Answer 2. The GAO was asked to assess whether BBA provisions will eliminate excess plan payments. The GAO report identified favorable selection, that is, enrollment of a healthier population of Medicare beneficiaries in managed care plans, as the primary cause of excess plan payments. GAO therefore concluded that implementation of risk adjustment will be the primary mechanism for reducing the excess. We agree with GAO that favorable selection has been the primary cause of excess plan payments. We are proceeding with implementation of a risk adjustment methodology for payments in 2000 as mandated by the Balanced Budget Act of 1997 (BBA).

However, GAO does not believe that excess payments will be completely eliminated without an adjustment of the 1997 base rates, which were overestimated by 4.2 percent. The BBA rate methodology does not allow for adjustments to overestimates in the previous years. Thus, this overstatement can only be corrected by legislation.

Question 3. Based on this GAO study, do you expect that Medicare+Choice plans will continue to be overpaid in the future?

Answer 3. Once again, we agree with GAO that implementation of risk adjustment will correct for favorable selection, the primary cause of excess plan payments. The 4.2 percent overstatement of the base rate cannot be corrected by HCFA administrative action. As a result, payments in FY 2004 will be about $3.0 billion higher than they would otherwise have been.

Question 4. What is the magnitude of the overpayments that have been made to Medicare+Choice plans in the past? Will these overpayments increase or decrease in future years?

Answer 4. The most recent analysis we did, to gauge the impact of the risk adjustment system we will initially be using for Medicare+Choice payments, shows that plans have on average been overpaid by about 7 percent. This will decrease steadily as we phase in the risk adjustment system over the next five years.

Medicare+Choice Plan Payments for the Beneficiary Information Campaign

Question 5. In their written testimony, the American Association of Health Plans (AAHP) expressed concern over the user fees that plans must submit for the Medicare beneficiary information campaign. AAHP noted that last year's campaign did not meet Congressional expectations because many Medicare beneficiaries did not receive correct or clear information. Would you care to comment?

Answer 5. Last year, we were successful in establishing an education program infrastructure to serve beneficiaries and to provide them with specific information about their health plan choices. We did a pilot test of the most beneficial means of communication with our beneficiaries. Activities included:

- distribution of materials to help beneficiaries understand their health plan choices in 5 pilot States (detailed handbook to pilot States and more general information to all other States.);
- establishment of a Medicare Choices Help Line to answer beneficiary questions and provide health plan information upon request which was initially piloted but expanded to all in 1999;
- development and implementation of the Internet web site (www.medicare.gov) to provide plan comparison information; and
- expansion of community-based outreach and education efforts; e.g., expansion of the State Health Insurance Assistance Programs to include choice counseling.

Additionally, we have developed a performance assessment system for all elements of the education program to use for continuous quality improvement. These assessment activities identify what is working well and what needs to be improved for each of the mechanisms for communicating information about Medicare+Choice. We are committed to improving the education program based on assessment results.

In forming any new and complex program, issues will arise. We conducted a pilot to proof our approaches before going national. In conducting the pilot, we did encounter circumstances that affected the accuracy of information provided to beneficiaries through the *Medicare&You* Handbook. The print production process for the Handbook begins in June. All information included in the Handbook must be finalized by that time. When the 1999 *Medicare&You* handbooks were printed, the information was correct. Errors in the handbooks, limited to the plan comparison information, were due to plan service area changes, such as non-renewals and service area reductions announced in October. To address this situation, the handbook for 2000 will contain general plan information, such as Medicare+Choice plan names, telephone numbers, ranges of premiums for plans available and a note if prescription drugs are offered. The handbooks will refer beneficiaries to the toll-free 1-800-

MEDICARE number and the www.medicare.gov web site for up-to-date and detailed information about the plans available to them in their area.

Question 6. HCFA has $25 million in user fees left over from last year. Could you please explain why you have extra money left over, and why you believe HCFA needs additional appropriations this year?

Answer 6. The $25 million in user fees left over from FY 1998 are from the toll-free line. Our original response rate estimate of 20 percent, based on analysis of comparable private sector endeavors, were too high. Based on current experience, we adjusted our operating assumptions to a response rate of 1% during normal workload months and up to 6% during peak months; e.g., during the fall when the handbook is distributed. We anticipate that these volumes will grow incrementally based on increased advertising and focus on the 2001 lock-in. A 10% rate for the peak is assumed in FY 2000.

We estimate a total need of $140 million for FY 2000. After allowing for the $25 million carry-over, we have a net need of $115 million in user fees. Our costs include: increased assessment efforts to ensure that the program is meeting beneficiary needs; new initiatives targeted to educating vulnerable populations; increased counseling services to beneficiaries; implementation of a Knowledge Base/Management system to enhance customer service; promotion and publicity enhancements; implementation of a long-term Internet strategy and enhancements; increased materials/publications development; and increased efforts around the Consumer Assessment of Health Plan Survey (CAHPS) to ensure that beneficiaries are being provided quality and comparison information about plans.

Question 7. Are managed care plan user fees paying for education efforts not solely related to managed care? Why should plans pay for unrelated education efforts?

Answer 7. The Balanced Budget Act of 1997 (BBA) specifies educational activities that we must conduct and that the funding source for these activities be a user fee collected from health plans. Before passage of the BBA, the Administration had proposed a broader fee that would be paid by all plans (Medigap), not just Medicare+Choice, to assist in financing all of our education efforts. However, what was passed under the BBA was an assessment of the user fee on Medicare+Choice plans only. Despite this, we have continued to supplement the user fee funding of Medicare+Choice education efforts with our own funding to support educational activities related to original Medicare.

QUESTIONS OF HON. RALPH HALL

Medicare+Choice Plan Withdrawals

Question 1. An April 1999 study of last year's plan withdrawals by the General Accounting Office found that many factors, not just low payment rates, contribute to a health plan's decision to leave the Medicare market or reduce its service area. Would you please comment on the results of this GAO study? Do you believe that similar factors have contributed to plan withdrawals this year?

Answer 1. Our analysis concurs with the GAO's finding that many factors contribute to plan business decisions regarding Medicare+Choice program participation. Different plans in similar market situations are making different decisions based on their own internal issues and corporate strategies. And, yes, similar factors did contribute to plan business decisions this year. We have conducted an analysis of plans that this year are leaving or diminishing participation in the program and of plans that are remaining, which is attached.

Question 2. Where did Medicare+Choice plans pull out of the market? Was it mostly in areas with the lowest payment rates?

Answer 2. Medicare+Choice plan pullouts were not primarily in areas with the lowest payment rates. Payment levels in counties affected by plan withdrawals range from the base rate of $401 to a high of $772 in Plaquemines Parish, Louisiana. In all, 329 counties in 33 states were affected. As mentioned above, we have conducted an analysis of plans that this year are leaving or diminishing participation in the program and of plans that are remaining, which is attached.

Question 3. In spite of plans complaining about low payment rates, I understand that more managed care plans are lining up to participate in the Medicare program. Is this correct?

Answer 3. Yes. Since January 1999, 22 new organizations received M+C contracts and 20 current organizations expanded their service areas. As of August 31, there are 13 new M+C applications and 9 Service Area Expansion applications pending.

Performance Standards

Question 4. I have heard it said that the performance standards that Medicare+Choice plans must comply with are difficult and cumbersome. I have two

questions for you about performance standards. First, aren't many of these health plans required to collect and report this data for other programs and other purchasers? Are the Medicare+Choice requirements really that much of a burden?

Answer 4. Yes, many, if not most, other programs and purchasers require similar reporting of performance measures. We believe that the performance standards required under Medicare+Choice are both reasonable and appropriate. Implementing this requirement is consistent with our responsibility to promote accountability on the part of managed care organizations. The collection, evaluation and reporting of performance measures are not new to managed care plans. Many Medicare + Choice (M+C) organizations collect and report data which include the Health Employer Data and Information Set (HEDIS), measures which are sponsored, supported and maintained by the National Committee for Quality Assurance (NCQA). HEDIS consists of standardized performance measures designed to help ensure that the public has the information it needs to reliably compare the performances of managed care plans. They are predictive of outcomes, are well-defined and are also well established and adopted in the private sector. In addition, an analysis of HEDIS measures gives purchasers and consumers the ability to evaluate health plan quality using important criteria, and to make plan decisions based upon demonstrated value rather than cost alone. The Medicare+Choice requirements also incorporate data currently being collected as part of voluntary accreditation efforts. Many managed care organizations have collected and reported standard measures as a requirement of accreditation.

We have been sensitive to concerns regarding the varying differences in health plan resources available to collect quality performance data relative to access and effectiveness of care. The quality assessment and performance improvement requirements established in the M+C regulation build upon a number of public-private efforts. We are working diligently to ensure that our requirements are consistent with those of private sector accrediting bodies. And we are strongly committed to implementing appropriate methods of performance measurement in the original Medicare program as well as in managed care.

Question 5. Second, it seems entirely appropriate that a program that has spent billions of taxpayer dollars should be held to performance standards. Do you agree that Medicare+Choice plans should be held accountable for their performance?

Answer 5. Yes, we certainly agree that Medicare+Choice organizations should be held accountable for their performance in providing the full range of services contained in their benefit packages to their enrolled members as well as providing the services in a manner that is in accord with acceptable clinical practice. Thus, in the Medicare+Choice regulations and policy, we are strengthening our commitment to being a value-based purchaser and requiring accountability from the health plans with Medicare contracts through the implementation of minimum standards.

To that end, we will be requiring health plans to meet minimum performance levels that will be measured through the collection of data such as HEDIS measures. We will be requesting input from all interested parties on the implementation of the minimum standards. As previously mentioned, we are strongly committed to implementing appropriate methods of performance measurement in the original Medicare program as well as in managed care.

MEDICARE+CHOICE:
CHANGES FOR THE YEAR 2000

An Analysis of the Medicare+Choice Program and How Beneficiaries Will Be Affected by Changes

A Report
by the
Health Care Financing Administration

September 1999

MEDICARE+CHOICE: CHANGES FOR THE YEAR 2000
EXECUTIVE SUMMARY

Since the creation of Medicare+Choice (M+C) in 1997, the Health Care Financing Administration (HCFA) has been working continuously to ensure that there is a wide range of high-quality health care options available to Medicare beneficiaries and to improve the operation of M+C for the private companies that choose to serve them. As part of this effort, HCFA has devoted a significant amount of time and effort to developing a better understanding of the program's successes and shortcomings. This report represents our latest effort to help Congress, the managed care industry, interested parties, and --most importantly-- Medicare beneficiaries and their advocates to understand how M+C is evolving.

BENEFICIARY ENROLLMENT AND MANAGED CARE ORGANIZATION PARTICIPATION

- *Beneficiary Enrollment* -- Total Medicare managed care enrollment has more than doubled in the past four years, from 3.1 million at the end of 1995 to 6.3 million in 1999. Approximately 33 million beneficiaries are in traditional fee-for-service Medicare.

- *Plan Participation* -- Plan participation has been somewhat volatile over time. In fact, the highest rate of increase in participating organizations (almost 40 percent) since 1986 occurred in 1994. The largest rate of decrease occurred in 1990 (almost 30 percent.) For both the 1999 and 2000 contract year, approximately 13 percent of the contracts were not renewed.

MEDICARE+CHOICE IN THE YEAR 2000 -- CHANGES IN EXTRA BENEFITS OFFERED

Although beneficiary access to prescription drugs and other non-Medicare benefits offered by M+C plans will remain relatively constant, many plans will restructure drug benefits in ways that increase enrollee out-of-pocket costs and limit drug coverage.

- *Drug Caps* -- In 2000, 86 percent of plans will have annual dollar limits (caps) on brand and/or generic drugs. The annual caps are becoming more restrictive. In 1999, only 21 percent of plans had an annual cap on drugs of $500 or less; in 2000, 32 percent of plans will have a $500 per enrollee benefit spending cap. Although enrollees will be more likely to have access to unlimited generic drug coverage, they will also be more likely to have even tighter caps imposed on brand-name drugs.

- *Copayments* -- There will be increased use of copays for prescription drugs. In fact, for the first time, all M+C organizations will charge copays for prescription drugs. In 1999, over one million beneficiaries live in areas with zero copayments for generic and brand name drugs. In 2000, all beneficiaries will live in areas with copays on both types of

drugs. On an enrollment-weighted basis that assumes M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees, average copays for brand-name drugs would increase by 21 percent, with average copayments for generic drugs increasing by 8 percent.[1]

- *Access to Extra Benefits Varies by State* -- Nationally, the number of beneficiaries with access to an M+C plan offering some prescription drug coverage will remain virtually unchanged next year. However, there will be state variation. Several states will have a substantial decrease in the number of beneficiaries with access to at least one M+C plan that provides a drug benefit. These states include Iowa, North Carolina, Nebraska, and Delaware. At the same time, a few states will have increased availability of drugs in 2000, including Virginia, New Hampshire, and Washington

MEDICARE+CHOICE IN THE YEAR 2000 -- CHANGES IN PREMIUMS

- *Increase in Premiums* -- For the M+C program overall, there will be an increase in the level of monthly premiums. For example, in 1999 on an enrollment-weighted basis, the average monthly premium for basic plans was $5.35. For 2000, this amount would almost triple to $15.84. Moreover, in 2000, the number of beneficiaries for whom the lowest available premium will be in the $20 to $60 range will increase by approximately 50 percent over 1999. Of the 207,000 beneficiaries who live in areas where the minimum monthly premium available is over $80, 94 percent (over 195,000) live in areas with only one plan available.

- *Decline in Plans with Extra Benefits for No Premium* -- In 2000, there will be a decline of about 3 million in the *number* of Medicare beneficiaries with access to a plan that does not charge for a premium for enrollment. This represents a decrease in the *percentage* of beneficiaries with access to any plan that does not charge a premium, from 85 percent in 1999 to 77 percent in 2000.

MEDICARE+CHOICE IN THE YEAR 2000 -- WITHDRAWALS AT THE END OF 1999

- *Plans Withdrawing From the Program* -- Over the past two years, a small percentage of beneficiaries have been affected by M+C withdrawals. In 1999, 407,000 enrollees (6.5 percent of M+C enrollees at the time in 1998) were affected, with approximately 51,000 (less than one percent of enrollees) being left without the option of enrolling in another M+C plan. Approximately half of beneficiaries affected by the withdrawals who still had an M+C option chose original fee-for-service Medicare and the other half chose to enroll in another organization.

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[1] As with all the enrollment-weighted analyses, this assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. Due to this assumption, HCFA refers to changes shown by this analysis as those that "would" (as opposed to will) occur.

For 2000, there were 327,000 enrollees affected (5 percent of M+C enrollees) and 79,000 (1.3 percent of enrollees) left with no M+C option. These beneficiaries were enrolled in 99 separate organizations that either withdrew entirely from the program or reduced their service area.

- *New Plan Approvals Will Help Improve Access* -- Despite volatility in the overall managed care marketplace, new organizations continue to come into the program. Since July 1998, 42 organizations have been approved for participation or expansion in the program affecting 400,000 beneficiaries in 87 counties. Of the 400,000 beneficiaries, 47 percent (approximately 200,000 beneficiaries) are residents of rural areas; of the 87 counties, 84 percent are rural. As of August 1999, there are 13 pending applications from organizations seeking new M+C contracts and nine requests for service areas expansions. Over 50 percent of the counties included in these pending applications currently have no M+C plans.

- *Access to Plans Reduced Slightly* -- As a result of terminations and service area reductions, overall access to M+C options will decline slightly in the year 2000, as it did in 1999. The trend of the decline in beneficiaries who had access to one or more M+C organizations has been slightly negative --in 1998, 72 percent of had such access; in 1999, the percentage declined to 71 percent; and for 2000 the percentage declined to 69 percent.[2]

- *Revenue and the Relation to Non-Renewal Decisions* -- Withdrawals of organizations from M+C are not primarily occurring in the lowest payment areas. They are disproportionately withdrawing from counties where payment rates are in a mid-range of $451 and $500 for the year 2000. If payment were the primary factor, one might expect withdrawals to be focused in counties with the lowest payments. Only 4 percent of enrollees in counties with the minimum payment level ($401) were affected. Yet, 12 percent of enrollees in counties with payments in the higher range of $451 to $500 were affected. Similarly, withdrawals do not appear to be correlated with low payment growth rates. Plan withdrawals will affect 7.2 percent of enrollees in counties where M+C payment rates are rising by 10 percent or more, but only affect 2.4 percent of enrollees where rates are rising by the 2 percent minimum.

MEDICARE+CHOICE IN THE YEAR 2000 -- PARALLELS TO PRIVATE SECTOR

- *The M+C Experience Corresponds to the Private Sector Experience* -- Program withdrawals, reduced benefits, and premium increases are not unique to Medicare. They reflect the

[2] The year 2000 figure is based on currently approved plans. The percentage will increase as new plan applicants enter the program.

industry-wide difficulty organizations have faced in the last few years in controlling costs while attempting to maintain quality and profit levels.

- *Factors Other than Payment Leading to Non-Renewal Decisions* -- Overall, the facts suggest that the General Accounting Office's findings about withdrawals for the 1999 contract year still hold true: causes other than payment rates appear to play a large role in business decisions to participate in M+C in 2000. Among the factors that appear to be relevant in both 1999 and 2000 are M+C enrollment levels in each contract, share of the local M+C market, the ability to maintain adequate provider networks, as well as strategic business decisions specific to a given organization.

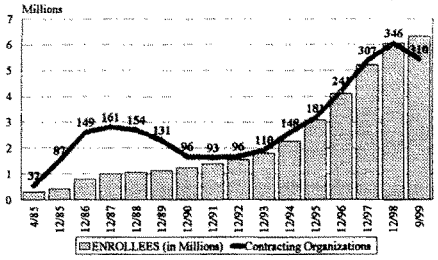
MEDICARE+CHOICE: CHANGES FOR THE YEAR 2000

Since the creation of Medicare+Choice (M+C) in 1997, the Health Care Financing Administration (HCFA) has been working continuously to ensure that there is a wide range of high-quality health care options available to Medicare beneficiaries and to improve the operation of M+C for the private companies that choose to serve them. As part of this effort, HCFA has devoted a significant amount of time and effort to developing a better understanding of the program's successes and shortcomings. This report represents our latest effort to help Congress, the managed care industry, interested parties, and --most importantly-- Medicare beneficiaries and their advocates to understand how M+C is evolving.

Beneficiary Enrollment and Managed Care Organization Participation

Despite recent volatility in the managed care market, an ever-increasing percentage of Medicare beneficiaries choose to enroll in M+C organizations.[1] Total Medicare managed care enrollment has more than doubled in the past four years, from 3.1 million at the end of 1995 to 6.3 million in 1999. About one in every six beneficiaries is now enrolled in an M+C organization, and the enrollment rate among those Medicare beneficiaries who live in an area served by one or more M+C

Medicare Risk HMO/M+C Enrollment and HMO Participation, 1985-1999

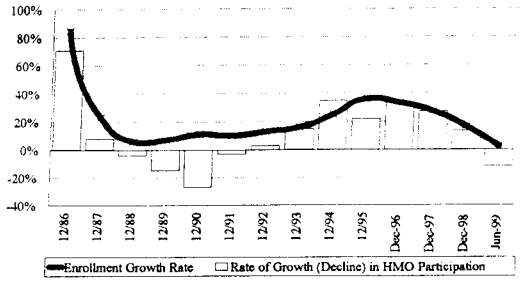


[1] As a result of provisions of the Balanced Budget Act of 1997 (BBA), the terms *organization* and *plan* have specific meanings in the context of the M+C program. The methodology section of the paper explains the difference in these definitions and the relevance to our analysis. Please see the methodology section for an explanation of several other key issues related to the development of this report.

organizations is about 23 percent (nearly one in four Medicare beneficiaries chooses an M+C plan where one is available).

We anticipate that program growth will continue in the long-term despite decisions by some organizations to discontinue participation in the M+C program for the 2000 contract year. Despite the fact that health maintenance organization (HMO) participation in the program has been volatile—and has even declined during certain periods—beneficiary enrollment has increased consistently. Enrollment losses resulting from reductions in organization participation in the 1999 contract year were recouped within just two months. Enrollment in Medicare risk organizations (today's M+C organizations) has grown every year since the inception of the program in 1985.

Yearly Medicare Risk Enrollment Growth Rates and Rates of Change in HMO Participation Levels, 1986-1999



Even though the level of access to M+C plans has remained relatively stable in the last few years, the absolute number of beneficiaries enrolling in M+C each month has dropped. During 1997, the size of the M+C program increased by 91,000 beneficiaries each month on a net average basis. Thus far, in 1999, the corresponding increase has slowed to 28,000 beneficiaries each month.[2]

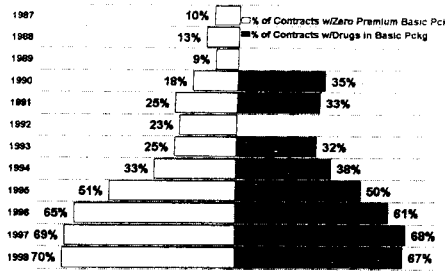
[2] In 1999, the net average monthly enrollment increase has been about 28,000 beneficiaries. This includes the large drop in enrollment due to the decisions made by M+C organizations in 1998 to withdrawal for the 1999 contract year. Subsequent to that drop, M+C enrollment has increased on a net average basis by over 40,000 beneficiaries per month during 1999.

Furthermore, the *rate of increase* in enrollment has declined recently. After 1986, the highest rate of increase in enrollment from one year to the next (36 percent) occurred between 1994 and 1995. Both prior to and after this period, enrollment growth has been more modest. However, the rate of enrollment growth for M+C in the late 1990s still exceeds the rate of growth in the number of beneficiaries entering the Medicare program overall.

The Medicare+Choice Program in the Year 2000

Although the majority of M+C organizations will remain in the program in the year 2000, many of these organizations will increase premiums, as well as reduce and restructure benefits. As a result, enrollee out-of-pocket costs will likely increase. A major factor behind this increase is the rising cost of offering prescription drug coverage—one of most attractive features of M+C for Medicare beneficiaries.

Historical Prevalence of Zero Premiums and Drug Coverage in Medicare Risk/M+C Contracts, 1987-1998



For missing years, data unavailable. Source: HCFA monthly managed care reports for 1990-1998, adjusted community rate proposals for 1987-1989 data.

Changes in Premiums and Benefits. Since the beginning of the Medicare risk/M+C program, the general trend has been towards an increase in zero premium[3] plans and the inclusion of drug coverage in the basic plan option regardless of any extra benefits (the basic option is generally the lowest-cost option available from an organization.)[4] In fact, since 1994, most plans have offered zero premium plans that include

[3] Please see the methodological note for a definition of zero premium.

[4] The paper later explains the difference in basic and optional supplemental benefits coverage.

drug coverage.[5] While access to a drug benefit has been relatively steady, there has been a decrease in the value of that extra benefit.

Prescription Drug Coverage. Nationally, the number of beneficiaries with access to an M+C plan offering some prescription drug coverage will remain virtually unchanged next year -- dropping only from 25.4 million beneficiaries (65 percent of the total) in 1999 to 25.2 million (63 percent of the total) in 2000. However, there is significant state-by-state variation. For example, the percent of beneficiaries who will have access to an M+C plan that offers any prescription drug coverage in 2000 will decrease significantly in a number of states, including Louisiana, North Carolina, and Delaware. Also, all available M+C plans will drop drug coverage *entirely* in four states (Arkansa, Iowa, Nebraska, and West Virginia.) At the same time, in a few states (such as Hawaii, Michigan, New Hampshire, and Washington) beneficiaries with access to M+C will have increased availability of drugs. (Please see Attachment A for a full state-by-state analysis.)

Access to Prescription Drug Coverage in Rural Areas is Stable. As mentioned above, there will only be a slight decrease in access to prescription drug coverage nationally. This is also true of rural areas. Among beneficiaries residing in rural counties, the number of beneficiaries whose M+C options do not include *any* level of drug coverage is roughly the same—433,000 in 1999 and 438,000 in 2000. This is an indication that the organizations withdrawing from rural areas generally did not offer drug coverage. While there is no change, the large disparity in access to prescription drug coverage in M+C in rural areas will continue. Only 4 percent of beneficiaries in rural areas will have access to prescription drug coverage through an M+C plan in 2000.

Decreasing Value of Drug Coverage. The *value* of the prescription drug benefit offered by plans will generally decline in 2000. This decline will be due to a number of factors, including decreases in the amount of drug spending covered (particularly for brand-name drugs) and increases in out-of-pocket costs for beneficiaries.

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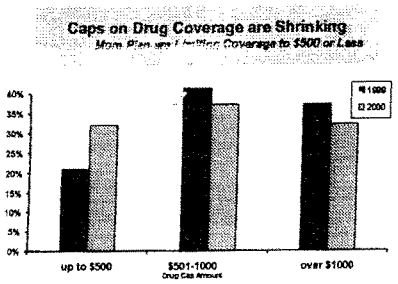
[5] With regard to the above chart, "Historical Prevalence of Zero Premiums and Drug Coverage," data for 1999 and 2000 are not available due to changes in the definition of M+C plans and organizations under the BBA.



More Restrictive Drug Caps Overall. Although a few additional plans will offer unlimited prescription drug benefits for both generic and brand-name drugs in 2000 relative to 1999, the vast majority of plans (86 percent) will continue limiting drug benefits next year. For organizations that do impose limits, the annual limits are more restrictive for 2000. For example, the percentage of plans with annual benefit limits of $500 or less will increase from 21 percent in 1999 to 32 percent in 2000. Furthermore, 82 percent of plans in 2000 will cap drug coverage below the $2000 level. On an enrollee level, there will be greater availability of unlimited generic drug coverage. At the same time, the caps on brand-name drugs will become more restrictive.

Basic Versus Optional Supplemental Drug Coverage. Although most Medicare beneficiaries will have drug coverage as a feature of their basic M+C plan, more beneficiaries in 2000 will have drug coverage available *only* as optional supplemental. If a covered item is in the basic package, only the plan's standard monthly premium (if any) applies. However, items that are covered as optional supplements require an additional monthly premium to be paid in addition to any premium already being charged for the basic plan. Benefits that are only available from a plan as optional supplemental are, by definition, are more expensive to obtain than benefits offered as basic coverage from that plan.

As a result of program changes, there is a greater likelihood that more generous drug coverage is only available with the payment of the additional premium needed to purchase the optional supplemental benefit. More beneficiaries will have to pay an additional premium for their drug coverage.

Copays for the Drug Benefit -- Plans Are Increasing Levels. Organizations are increasing copays for both brand name and generic drugs.

For the first time, all organizations will require copays for drugs. In 1999, over one million beneficiaries live in areas with an M+C option that allows zero copayments for generic and brand name drugs. In 2000, all beneficiaries in such areas will be subject to copays on both types of drugs.

In 1999, 20 percent of beneficiaries are offered plans with copayments averaging $5 or less for generic drugs. The comparable percentage in 2000 will be three percent. Furthermore, the percentage of all beneficiaries faced with average copayments for generic drugs in the $10 to $15 range will triple. Finally, in 1999, only 274,000 of all beneficiaries live in an area with copayments on brand-name drugs averaging $25 or more. In 2000, there will be one million beneficiaries facing that level of copayment.

Copays and the Drug Benefit -- Beneficiary Charges are Increasing on Average. Overall, M+C enrollees would, on average, be subject to higher copay levels. Assuming M+C enrollment levels remain constant from 1999 to 2000 and that different M+C organizations maintain their same proportion of enrollees, the average copayment for brand name drugs would increase by 21 percent between 1999 and 2000 on an enrollment-weighted basis. Using the same type of analysis, the data show that copays on generic drugs would increase by an average of 8 percent between 1999 and 2000.[6]

[6] As with all the enrollment-weighted analyses, this assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. Due to this assumption, HCFA refers to changes shown by this analysis as those that "would" (as opposed to will) occur. Please see the methodological note for further detail.

Copayment Levels in M+C Plans and Averages Weighted by Enrollment 1999 and 2000[7]		
	Brand-Name Copay: Enrollment Wtd. Avg.	Generic Copay: Enrollment Wtd. Avg.
1999	$14.34	$6.88
2000	$17.30	$7.42
Percent Increase 1999 to 2000	21%	8%

Other Benefits. The coverage for other, extra benefits not covered by Medicare fee-for-service (such as dental, vision, and hearing aid benefits) will remain substantially unchanged from 1999 to 2000 in M+C plans. For example, the percentage of the total Medicare beneficiary population living in an area with M+C plans that offer dental benefits will only drop from 83 percent in 1999 to 80 percent in 2000. Similarly, access to vision coverage remains unchanged at 99 percent in both 1999 and 2000.

Changes in Premiums. For 2000, despite some state by state variation, there is a clear trend toward increasing premiums for M+C plans—especially in rural areas. There has been a corresponding decline in the number of zero premium plans. Furthermore, though relatively small numbers of beneficiaries are involved, there will be a significant increase in the number of beneficiaries who will have to pay relatively high premiums to enroll in an M+C plan.

Decline in Zero Premium Plans. In 2000, there will be a decline of more than 3 million in the *number* of Medicare beneficiaries with access to at least one zero premium plan. This represents a decrease in the *percentage* of beneficiaries with access to any plan who will have a zero premium plan, from 85 percent in 1999 to 77 percent in 2000.

[7] This chart includes data from plans with any level of drug coverage in the basic plan.

The corresponding drop in rural areas is greater. One-half million fewer rural beneficiaries will have access to a zero premium plan. In 1999, 1.3 million rural beneficiaries (63 percent of those with any plan available) live in an area with at least one zero premium plan; in 2000, only 784,000 rural beneficiaries (40 percent of those with any plan available) will have such an option.

Some states will see significant changes (positive and negative) in the number of zero premium plans that are available. In the table below, a negative change is an indication that access to zero premium plans is being reduced.

Zero Premium Plan Availability, Changes Over 5% 1999-2000[8]				
State	Beneficiaries with Access to Plans	Beneficiaries with Access to a Zero Premium Plan		
		1999	2000	Change
NEW HAMPSHIRE	170,050	100%	0%	-100%
KANSAS	398,171	92%	45%	-47%
ARKANSAS	447,359	72%	35%	-37%
MISSOURI	876,461	88%	56%	-32%
CONNECTICUT	522,372	90%	63%	-27%
PENNSYLVANIA	2,133,804	78%	57%	-21%
WASHINGTON	742,235	82%	61%	-21%
WISCONSIN	797,476	87%	66%	-21%
LOUISIANA	618,618	100%	84%	-16%
NEW JERSEY	1,220,622	100%	86%	-14%
FLORIDA	2,835,297	92%	80%	-12%
MASSACHUSETTS	979,167	100%	94%	-6%
CALIFORNIA	3,937,181	97%	91%	-5%
OHIO	1,735,412	79%	84%	5%
TEXAS	2,273,849	92%	98%	6%
VIRGINIA	885,285	32%	44%	12%
MARYLAND	647,249	83%	96%	13%
WEST VIRGINIA	344,377	0%	32%	32%
TENNESSEE	838,289	50%	83%	33%
OKLAHOMA	516,047	3%	96%	94%

[8] The percentage of beneficiaries with access to a zero premium plan may increase or decrease solely because the number of beneficiaries with access to any M+C plan has increased or decreased.

Increases in Premiums. Data show that there will be an increase in the level of those premiums in M+C. For example, in 1999, the enrollment-weighted average premium for a basic plan was $5.35. For 2000, this amount would almost triple to $15.84.[9] Measured in terms of access to plans across the entire Medicare population, the number of beneficiaries living in areas where M+C premiums are in the $20 to $60 range will increase by approximately 50 percent in 2000 over 1999 representing a shift from lower groups. Finally, for 1999, only 50,000 Medicare beneficiaries live in an area where the minimum premium is in the $80 to $100 range; however, in 2000, the number will rise to 207,000. The majority of such individuals (60 percent) are residents of rural counties.

Premiums in Areas with Only One Plan. Medicare beneficiaries who live in areas with a choice of only one plan will be particularly affected by premium increases. Approximately 8 percent of M+C beneficiaries (just over three million) live in areas with a choice of only one plan. However, of the 207,000 beneficiaries who live in areas where the minimum monthly premium available is over $80, 94 percent (over 195,000) live in areas with only one plan available. There will be a nearly six-fold increase—from 1.6 percent to 9.3 percent—in the percentage of beneficiaries who live in an area where the sole M+C plan available has a monthly premium in the $80 to $100 range for 2000.

Minimum Premium	Medicare Beneficiary Population (Total), Access to Only One Plan			
	Year 1999		Year 2000	
	Beneficiaries	%	Beneficiaries	%
Zero	803,162	31.6%	599,553	28.4%
$0.01 - $19.99	17,614	0.7%	-	0.0%
$20.00 - $39.99	467,284	18.4%	410,662	19.5%
$40.00 - $59.99	716,662	28.2%	683,029	32.4%
$60.00 - $79.99	499,095	19.6%	220,237	10.4%
$80.00 - $99.99	39,742	1.6%	195,432	9.3%
Totals	2,543,559	100%	2,108,913	100%

[9] Again, please see the methodological note to learn that the enrollment-weighted analysis assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. This average does not include premiums that beneficiaries pay for supplemental plans.

Premium increases in areas with only one plan will have the most pronounced impact in rural areas. From 1999 to 2000, roughly the same percentage of beneficiaries who live in rural areas will have only one plan available --28.4 percent and 29.6 percent in each year respectively. However, the table below shows that zero premium plans are becoming less widely available in rural areas. It also shows that there will be a significant increase in the number of rural Medicare beneficiaries whose only M+C option is a relatively high cost plan.

Minimum Premium	Medicare Beneficiary Population (Rural Only) Access to Only One Plan			
	Year 1999		Year 2000	
	Beneficiaries	%	Beneficiaries	%
Zero	271,833	37.7%	174,956	28.1%
$0.01 - $19.99	17,614	2.4%	-	0.0%
$20.00 - $39.99	96,131	13.3%	104,796	16.8%
$40.00 - $59.99	135,440	18.8%	146,425	23.5%
$60.00 - $79.99	160,647	22.3%	81,774	13.1%
$80.00 - $99.99	39,742	5.5%	115,669	18.5%
Totals	721,407	100%	623,620	100%

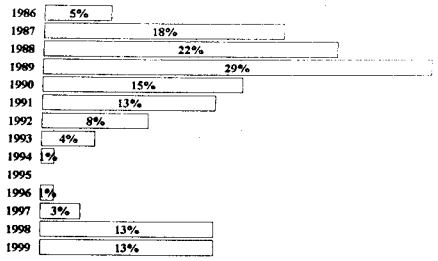
Other Cost Sharing. As with drug coverage, copayments and coinsurance for office visits are increasing. The enrollment-weighted average copayment across all plans for a primary care office visit would increase by 20 percent, from $6.90 in 1999 to $8.33 in 2000. The enrollment-weighted average copayment across all plans for a specialty visit would increase by 37 percent, from $7.67 in 1999 to $10.52 in 2000.[10]

[10] Please see methodological note for information on enrollment-weighted averages.

Access to Medicare+Choice Plans at the End of 1999

This year and last, a number of organizations decided to end or reduce their participation in the M+C program. For 2000, 99 M+C organizations will reduce or drop participation in the program. This includes 41 contractors that completely terminated their M+C contract and another 58 contractors that reduced the size of the service area. These changes will affect 327,000 M+C enrollees (5 percent of enrollees) across 329 counties within 33 states. Of the 327,000 affected, 79,000 M+C enrollees (1.3 percent of enrollees) will have to return to traditional Medicare because they will not have an M+C plan available in their county. This is in contrast to the 407,000 M+C enrollees (6.5 percent of enrollees) affected by contract nonrenewals and service area reductions in 1999. Of the 407,000, 51,000 M+C enrollees (less than one percent of enrollees) were left without access to another M+C plan.

Risk Contract Non-Renewals by Percent of Plans, 1986-1999
(Excludes Service Area Reductions)



Refers only to risk non-renewals (including conversion to cost plans), not service area reductions. The 1989 figure includes 29 plans that had no enrollees. The percent for 1995 was less than one. 1999 data are based on the number of plans as of August 1999.

Terminations of contracts by managed care organizations still remain well below the rates experienced a decade ago. In 1988, 22 percent of Medicare managed care organizations withdrew from the program entirely. This affected 8.2 percent of enrollees.[11] Similarly, in 1989, 29 percent of organizations terminated their contracts, affecting 6.6 percent of enrollees. The high percentage of withdrawals in the late 1980s and then the withdrawals in the late 1990s (13 percent in 1998 and again in 1999) are a stark contrast to the stability experienced from 1993 to 1997.[12]

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[11] The data in this paragraph pertain only to contract terminations, not to service area reductions because HCFA does not have complete historical data on the number of beneficiaries affected by service area reductions.

[12] The term withdrawal is generally used to include both organizations that reduced their service areas or completely terminated their contracts for 2000. In 1998 and 1999, 13 percent of organizations terminated their contracts, with 3.7 percent and 2.7 percent of beneficiaries affected each year (exclusive of service area reductions). With reference to the chart "Risk Contract Non-Renewals," the number of plans in 1999 are for the 2000 contract year.

New Plan Approvals Will Increase Availability. Despite volatility in the overall marketplace, new organizations continue to enter the program. Since July 1998, 42 organizations have been approved for participation or expansion in the program. As of August 1999, there were 13 pending applications from organizations seeking new M+C contracts, and nine pending requests for service area expansions.[13] Over 50 percent of the counties included in these pending applications currently have no M+C plans. If approved, these applications would bring M+C access to an additional 1.5 percent of total Medicare beneficiaries.

For 2000, 262 organizations will continue their M+C contracts with Medicare. With the additional 13 new applications, the number of contractors operating in 2000 would be at least 275. As a result, the net percentage decrease in contracting organizations from 1999 to 2000 would be 10 percent --a slightly lower percentage decrease than was experienced in 1998 and 1999 (13 percent in each individual year as shown on the previous page).

New Plan Approvals Will Especially Help Rural Areas. For counties where there were no M+C plans in March of 1999, applications have already been approved that will result in 400,000 additional beneficiaries (living in 87 counties) gaining access to M+C plans for 2000. Of the 400,000 beneficiaries, 47 percent (approximately 200,000 beneficiaries) are residents of rural areas; of the 87 counties, 84 percent are rural. It is also interesting to note that the 400,000 beneficiaries gaining new M+C plans represent only one percent of the total number of beneficiaries; but, the 200,000 rural beneficiaries who will have an M+C plan represent 2.2 percent of rural beneficiaries. For all pending applications from organizations to begin or to expand participation in M+C, 51 percent of the applications are for rural counties. Plans are not simply expanding into high payment areas; only three of the 87 counties being added will have an M+C payment over $450 in the year 2000 (with 2,200 enrollees in the three counties).[14]

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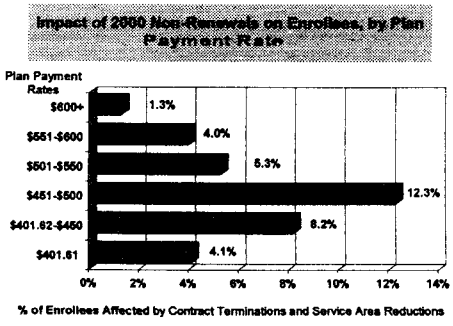
[13] This does not include the pending application for the private fee-for-service plan.

[14] The average M+C base county payment for 2000 for aged beneficiaries, weighted by county beneficiary populations in all US counties, exclusive of US territories, is $513 ($491 in 1999). The simple average of county payment rates for 2000 is $452 ($427 in 1999), with the minimum in the US counties (exclusive of territories) set at

Access to M+C Organizations. As a result of terminations and service area reductions, overall access to M+C options will decline slightly in the year 2000, just as it did in 1999. The percentage of all beneficiaries with access to one or more M+C organizations has declined steadily in recent years --from 72 percent in 1998, to 71 percent in 1999, and to 69 percent for 2000.[15] (Please see Attachment B for a state-by-state analysis of beneficiary access to M+C organizations.)

Access Differences in Rural Areas. Beneficiaries in rural areas will be disproportionately affected by the withdrawal decisions made by M+C organizations for 2000. While access to an M+C plan in urban areas will decline by about 4 percent, access to M+C plans will decline in rural areas by about 10 percent.[16]

Medicare Revenue and Its Relation to Non-Renewal Decisions. Contrary to assertions by some industry sources, the level of payments to organizations does not appear to explain the decisions by M+C organizations to withdrawal from --reduce or discontinue participation-- the program. Organizations are primarily withdrawing from counties where payment rates are in a payment mid-range of $451 and $500 for the year 2000. If payment were the primary



$401.61 ($379.84 in 1999), the maximum $814 ($798 in 1999), and the median $435 ($401 in 1999).

[15] The year 2000 figure is based on currently approved organizations. The percentage will increase as new applicants enter the program.

[16] Although 83 percent of urban beneficiaries will have access to M+C plans in 2000 (down slightly from 86 percent of urban beneficiaries in 1999), only 21 percent of rural beneficiaries will have access to an M+C plan in 2000 (down from 23 percent in 1999.) The drop from 21 percent to 23 percent represents a 10 percent shift.

factor, one might expect withdrawals to be focused in counties with the lowest payments. Only 4 percent of enrollees in counties with the minimum payment level ($401) were affected. Yet, 12 percent of enrollees in counties with payments in the mid-payment rate range of $451 to $500 were affected. Fully, 96 percent of M+C enrollees who are currently in M+C organizations operating in "floor" counties can retain their current M+C plan in the year 2000. Enrollees in counties with the highest payment rates were less likely to be affected by non-renewals. In fact, only 1.3 percent of affected beneficiaries are enrollees in counties where payments are $600 or higher.

Payment will increase in all counties this coming year by an average of 5 percent.[17] The range of payment increases vary from 2 percent to 18 percent.[18] These increases are the result of the Balanced Budget Act (BBA) reforms designed to bring more plan choices to beneficiaries and level the playing field across geographic areas by increasing payment in counties that had the lowest rates. Yet, counties receiving some of the largest increases under the BBA payment system will experience the most disruption. Organization withdrawals will affect 7.2 percent of enrollees in counties where rates will rise by 10 percent or more, but will affect only 2.4 percent of enrollees in counties where rates will rise by the minimum increase of 2 percent.

In addition to M+C payments from HCFA, another source of revenue for M+C organizations is the collection of premiums and other cost sharing from Medicare enrollees. The relation between the availability of a zero premium plan and the level of payment in a given county remains virtually unchanged between 1999 and 2000. If Medicare payments were insufficient for the revenue needs of organizations, one would expect to find zero premium options being limited to the highest payment areas. The data do not show that to be the case.

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[17] Calculation based on the average weighted by county Medicare beneficiary populations.

[18] Please note that the 18 percent increase was in an Alaskan county that does not have an M+C option available. The highest percentage payment level increase for a county with an M+C option is 12 percent.

Average HCFA M+C Payment for Counties with at Least One $0 Premium Plan						
	1999			2000		
	Urban	Rural	Total	Urban	Rural	Total
Simple Average	$500.36	$450.49	$483.88	$499.08	$445.02	$483.39
Weighted Average	$539.47	$455.72	$534.41	$535.05	$449.86	$531.57

Comparison of Benefits of Dropped Contracts and Counties to the Overall M+C Program. Organizations withdrawing from M+C are not significantly different than organizations remaining in M+C for the 2000 contract year in terms of benefits. Among all M+C enrollees, 84 percent are enrolled in an organization where the basic plan offers some level of drug coverage. The percentage is similar for enrollees affected by withdrawals; 79 percent are enrolled in an organization where the basic plan offers some level of drug coverage.

Other Factors Affecting Non-Renewal Decisions. In its analysis of the M+C terminations and service area reductions occurring for the 1999 contract year, the General Accounting Office concluded that a variety of factors other than payment rates played a role in organizations' decisions regarding participation in the M+C program. Given that payment cannot be directly correlated with such decisions regarding M+C contracts for the year 2000, it appears that other factors continue to play a large role in determining the level of organizations' participation in M+C. Among the factors that appear to be relevant in both 1999 and 2000 are M+C enrollment levels in each contract, share of the local M+C market, the ability to maintain adequate provider networks, as well as strategic business decisions specific to a given organization.

Different organizations have made different business decisions regarding their participation in the M+C program. Cigna Corporation has substantially reduced its participation through withdrawals and service area reductions affecting at least a quarter of all the corporations M+C enrollment. Cigna will have about 125,000 remaining M+C enrollees as a result of these changes. By contrast, there will be a minimal effect among enrollees of the largest M+C contractor, PacifiCare, which has over one million M+C enrollees. Fewer than one percent of PacifiCare's M+C enrollees were affected by

terminations or service area reductions. The PacifiCare termination involved a contract that included only one county in Oregon, where PacifiCare had a 24 percent M+C market share, but the county is a floor payment county ($401.61 payment in 2000). PacifiCare's service area reductions involved counties where the organization had an average market share of 23 percent, including Eastern Washington, where PacifiCare is leaving both Medicare and commercial markets. However, small numbers were involved. The average number of enrollees in the affected counties is under 1,500 (and the average payment level is $494).

As another illustration, Kaiser is withdrawing from markets in eastern and southern states for both M+C and other lines of business. The organization is terminating the M+C contract of its Capital Area Community Health Plan in upstate New York. A comparison between that contract and Kaiser's M+C contract in Oregon, where the M+C contract will remain in place in 2000, shows that the M+C characteristics are very similar: each has small enrollment, relatively low payment rates, modest benefit packages, and substantial market share (particularly Capital Area), yet Kaiser has chosen to terminate only one of the contracts. Therefore, it seems that other factors have led to a decision not to renew one of the contracts even though the HMOs' revenues and benefit structure are similar in each location.

	Enrollment (mid-1999)	M+C Market Share	1999 Weighted Monthly Average M+C Payment	Weighted Monthly Plan Premium in Service Area	Nature of Drug Benefit Limit
Kaiser of the Northwest	35,000	26%	$394	$75	Unlimited, but 70% coinsurance
Capital Area	17,000	73%	$419	$25	Annual limit of $500, $1000 varying by county

A number of organizations have made reference to their inability to maintain viable networks in their public statements regarding termination decisions. For example, the Group Health Cooperative in Washington State announced that it was discontinuing operations (for all lines of business, Medicare and others) in eleven rural counties in the State—the first time in the 52-year history of the

organization that it has taken such an action. The organization's press release cited its inability to maintain a viable provider network as a contributing factor.

In another example, despite a generous payment rate of $592, Oxford left 9,100 enrollees in Suffolk County, New York because of provider network difficulties.

Parallels of the Medicare+Choice Experience to the Private Sector

Volatility in the marketplace is not confined to Medicare. Program withdrawals, reduced benefits and premium increases are not unique to Medicare. They reflect the industry-wide difficulty organizations have faced in the last few years in controlling costs while attempting to maintain quality and profit levels. These challenges facing managed care organizations have been widely reported in the financial and trade press and are related to the business decisions that organizations are making.

There are many examples of health plans withdrawing from markets other than Medicare. As discussed in the earlier section, PacifiCare is withdrawing from both Medicare and commercial markets in several Washington State counties. Also, Group Health Cooperative is pulling out of both Medicare and non-Medicare markets in 14 counties in eastern Washington and northern Idaho, citing a variety of reasons for its decision. And in several north-eastern markets, Kaiser Permanente is withdrawing from Medicare, Medicaid, and its commercial business, affecting about 500,000 enrollees. Kaiser has specifically said that its withdrawal from these markets cannot be attributed to changes in Medicare payments.

Over the last two years, the Federal Employees Health Benefits Program (FEHBP, with 9 million enrollees) has seen the same kinds of changes that the M+C program has experienced. At the end of 1998, about 20 percent of participating HMOs withdrew from the FEHBP program. At the end of 1999, it is expected that about 13 percent of plans will withdraw from FEHBP. Premiums in FEHBP increased by 7.2 percent for 1998 and slightly over 9.5 percent for 1999. Increases for 2000 will average 9.3 percent.

There also are many examples of health plans raising premiums and reducing benefits in other markets. The California Public Employees Retirement System (CalPERS), which covers over 1 million people, agreed to an average premium increases of 7.3 percent for 1999 and more than 9.7 percent for 2000— the largest premium increase in CalPERS since 1991.

HCFA actuaries are predicting increases of nine percent in private health plan premiums for the year 2000 on average. According to Towers-Perrin, large employers experienced a 7 percent increase in average health insurance premiums for active workers in 1999. One finding in the survey was that rate increases for HMO products in 1999 equaled or exceeded the increases for traditional indemnity plans.

It is essential to note that the large increases now common in the private sector follow several years when private sector increases were quite small--the so-called "underwriting" cycle. In those same years, Medicare increases were two to three times higher than private sector increases, and in fact some financial analysts have pointed out that Medicare revenues subsidized premiums of other payers. Those years of excessive Medicare payment increases greatly contributed to the ability of organizations to provide generous benefit packages. As the cycle continues, plans are finding that they cannot use Medicare revenues to subsidize other lines of business despite statements made by the General Accounting Office and others that M+C pays plans more than adequately for the provision of the Medicare benefits package.

Conclusions

Managed care organizations are now experiencing programmatic and financial challenges. Although public and private markets are structured somewhat differently, managed care's difficulties are producing important changes that affect all their products, including their participation in M+C.

Organizations are increasing premiums for private and public sector purchasers alike. Enrollees (in both private and public products) are finding that many plans are restructuring benefits to increase cost sharing or reduce the level of coverage available (particularly for drug coverage). In M+C, there

has been clear movement towards rethinking market strategies--including corporate decisions to exit particular markets. Moreover, there is a movement towards increasing out-of-pocket costs for enrollees and reducing the level of benefits provided. At the same time, the M+C program continues to receive new applications that will increase access to managed care for beneficiaries, especially in lower paid areas.

METHODOLOGICAL NOTE

Definitions

- **Plans and Organizations** -- In a context other than Medicare+Choice (M+C), the term *plan* (or *health plan*) is generally understood to mean a health benefit offering of a particular insurance company or health maintenance organization (HMO.) In Medicare, the term has a special meaning as a result of provisions of the Balanced Budget Act of 1997 (BBA). Prior to the BBA changes, a Medicare-contracting HMO was commonly referred to as a "plan," and the plan could offer a variety of benefit packages—for example, one plan could offer several optional supplemental benefit packages available to Medicare enrollees for an additional premium; or a plan could vary its Medicare benefit offerings in different counties, under certain circumstances. The BBA changes give a specific meaning to the term *plan* that is different from prior usage of the term. Under the BBA, the various offerings of a contracting HMO or other organization are referred to as "plans." The "plans" may vary by the level of benefits provided ("plans" that offer extra benefits for enrollees choosing to pay an additional premium); or they may vary by the structure of the "plan" (one organization may offer a "plan" structured as a PPO under its M+C contract while, at the same time, offering, in the same service area, a "plan" structured as a closed-panel HMO). The term *plan*, under the BBA, continues to include what were referred to in pre-BBA terminology as "high option" plans or supplemental offerings available for an additional premium (please see below for a definition of optional supplemental coverage.)

  Under the BBA provisions, "plans" offered by an *organization* may have different service areas under a single contract. However, each "plan" offered by a contracting organization must have a uniform benefit and premium structure throughout the approved service area of the "plan"; that is, once a "plan" is offered in multiple counties under one contract, all residents of all the counties where the "plan" is offered must receive the same level of benefits if they choose that plan. Another way in which an M+C organization may offer more than one plan under one contract is through "segmented service areas." The segmented service area provision is the successor to the pre-BBA "flexible benefits" policy under which an

organization could vary premiums and benefits under one contract on a county-by-county basis. The segmented service area policy allows organizations to essentially set up multiple service areas under a single contract in such a way that each sub-service area has a different "plan" (enabling the organization to comply with the BBA requirement of uniform premiums and benefits within a service area—a requirement that applies at the plan level, not at the organization level).

- **Zero Premium** -- If there is not a monthly charge beyond the regular Part B Medicare premium to enroll in a risk/M+C organization, then the organization is said to have a "zero premium." All M+C enrollees must continue to pay their Part B premium (or have it paid on their behalf). Organizations that charge the beneficiary a monthly amount in addition to the Part B premium to enroll are not considered zero premium organizations.

- **Beneficiaries and Enrollees** -- For reasons described in the Methodology Section of this Note, beneficiary and enrollee are used in specific ways for purposes of this paper. "Beneficiary" is used to refer to all Medicare beneficiaries—those both enrolled in original fee-for-service Medicare and those enrolled in M+C. "Enrollee" is used to refer to those persons actually participating in a managed care plan --whether that plan is part of M+C or a private program.

Methodology

The analyses in this paper present data from a variety of sources. However, the analysis is primarily based on data submitted by M+C organizations to HCFA. Data are arrayed and presented along different dimensions, but generally fall into one of three categories:

- Plan-level data,
- Population-level data, based on the level of the total Medicare beneficiary population in a county, a state, a sub-area (e.g., rural areas), or in the nation as a whole, and
- Enrollment-level data, based on enrollment in M+C organizations in 1999.

Plan-Level Data. BBA policy changes related to the designation of "plans" applied to M+C contracts for 1999. In 1999, although there are about 300 contracting organizations, 622 "plans" are offered to beneficiaries by M+C contractors. In the year 2000, although there will be about 260 contractors, they will offer 793 different plans to beneficiaries. These 793 plans include both the "high option" supplements available for an additional premium, as well as "plans" that represent inter-county variation in premiums and benefits. The growth in segmented service areas has contributes to the growth in the number of plans.

The plan-level analyses in the paper are analyses across all "plans" under the BBA definition of the term. For example, in the data, an average premium among all plans would be computed across all 793 plans in 2000, or across all 622 plans in 1999. Because the set of "plans" includes optional supplemental packages, and HCFA does not collect data on the number of M+C enrollees who elect optional supplements offered by their M+C organization, the plan-level analysis only provides a rough indicator of what is happening at the beneficiary level. However, the plan-level analysis can provide an indication of the general trends and changes from year to year in plan offerings that beneficiaries will see. In addition, the plan level analysis does not account for the fact that each plan contains a different number of enrollees. By failing to appropriately weight the policies of a given plan by the number of enrollees in that plan, this type of analysis may not provide an accurate picture of how the enrollee population is affected by a given policy.

Population-Level Data. Another way in which data are presented in this paper is at the level of the overall Medicare beneficiary population. Plan benefits and premiums are analyzed in terms of the number of Medicare beneficiaries residing in the counties in which the M+C organizations are offering their plans. That is, the data provide a means of showing what beneficiaries across the Nation—including beneficiaries enrolled currently in an M+C plan, as well as those not enrolled currently—can expect in the way of benefit offerings from M+C organizations operating in the counties where they live. Overall access figures (e.g., data on whether or not any M+C plan is available to beneficiaries) are also presented using beneficiary population numbers that include both

beneficiaries enrolled in M+C plans and non-enrollees. The population-level data in almost cases are combined with plan-level data. For example, a statement to the effect that a certain number of beneficiaries will have access to plans in which the average premium level is a certain dollar figure includes an averaging across all "plans." For 2000, the analysis assumes the beneficiary population by county as February 1, 1999.

Enrollment-Level Data. Until beneficiaries decide, for the year 2000, whether to continue their M+C enrollment, change to another M+C organization, or newly enroll into or disenroil from an M+C organization, enrollment levels for 2000 will not be known. However, in order to provide more information about what kinds of changes in their premiums and benefit packages beneficiaries may see in the year 2000, this paper provides an analysis of the differences between 1999 and the year 2000 in *basic benefit packages* offered by M+C organizations that were operating in February of 1999 and will continue to operate in the year 2000. To offer an indication of the possible impact of benefit changes on the current M+C enrolled population, the analysis uses the actual distribution of enrollment in 1999 to assign enrollment numbers to organizations for the year 2000 for purposes of analyzing the data on benefits and premiums and to examine how beneficiaries may be affected by changes made by the organizations in which they are currently enrolled. That is, the analysis presents the changes in the M+C program using the assumption that (a) enrollment levels will remain the same, and (b) different organizations will have the same proportion of M+C enrollment, as a share of overall M+C enrollment, that they had in 1999.

An element of the enrollment-level analysis is the identification of a basic benefit package (or basic "plan") in 1999 and 2000 to establish the minimum level of benefits available to an M+C enrollee in a particular organization. The basic package is also used as the unit of analysis because, as noted above, HCFA does not have enrollment information regarding optional supplemental packages.[19] The basic package is identified at the county level to account for segmented service areas (which would

[19] Beneficiaries enrolled in M+C plans as employer-sponsored retirees may have additional benefits beyond those offered to individual Medicare beneficiaries; however, HCFA does not collect data on the nature of such benefits.

have different benefit packages). It is generally assumed that a plan that has a zero premium is the basic package. Where two plans in the same county offered by the same organization have a zero premium, the plan with the more generous benefit package is assumed to be the basic plan (particularly if one plan provides some level of drug coverage and another zero premium plan offered in the same county by the same organization does not). Co-existing zero premium plans may be offered by one organization in the same county for a number of reasons. One of the organization's zero premium plans may have extra benefits covered because the competing zero premium plan is a point-of-service option allowing greater use of non-network providers. In certain states, organizations may also offer zero premium plans that do not include drug coverage (but have, for example, lower copayments for physician visits) along with a zero premium plan that does cover drugs. This is done in order to offer a "plan" that is attractive to Medicare beneficiaries who obtain their drug coverage from sources such as state pharmacy assistance programs. In such a case, the analysis treats the plan with a zero premium *and* drug coverage as the "basic package" offered to any Medicare beneficiary residing in the county where the organization offers various plans. Where multiple options are offered by the same organization and all require the payment of a premium (beyond Medicare's Part B premium), the lowest-cost plan is assumed to be the basic plan.

The enrollment-level data therefore:

- Impute enrollment levels for 2000, based on a methodology that assumes, essentially, that enrollment levels, and the enrollment distribution among plans, remain static between 1999 and 2000;
- Refer only to what the analysis treats as a "basic benefit" in each county for each organization (i.e., one "plan" is chosen to be the basic benefit package for each organization operating in a county); and
- Present data aggregated at the imputed enrollment level. For example, an enrollment-weighted premium for this group would be the actual average premium across all unique basic plans in 1999. The imputed year 2000 average enrollment-weighted premium for the unique basic plan average across the 1999 enrollees of the organizations in the individual counties that the organization continues to include in its service area.

ATTACHMENT A

Changes in Access to Any Drug Coverage for Beneficiaries with Access to at Least One M+C Plan 1999-2000 *Negative change indicates drop in coverage.*			
State	**1999**	**2000**	**Change**
AK	100%	100%	0%
AL	0%	0%	0%
AR	37%	0%	-37%
AZ	100%	100%	0%
CA	99%	98%	-1%
CO	100%	100%	0%
CT	100%	100%	0%
DC	100%	100%	0%
DE	100%	58%	-42%
FL	97%	98%	0%
GA	100%	100%	0%
HI	0%	100%	100%
IA	100%	0%	-100%
ID	100%	100%	0%
IL	92%	92%	0%
IN	100%	100%	0%
KS	100%	100%	0%
KY	100%	100%	0%
LA	93%	84%	-10%
MA	100%	100%	0%
MD	100%	100%	0%
ME	100%	100%	0%
MI	89%	100%	11%
MN	100%	100%	0%
MO	100%	100%	0%
MS	100%	100%	0%
MT	100%	100%	0%
NC	72%	18%	-55%
ND	0%	0%	0%
NE	100%	0%	-100%
NH	72%	100%	28%
NJ	100%	100%	0%
NM	100%	80%	-20%
NV	100%	100%	0%
NY	89%	88%	-1%
OH	98%	96%	-2%

Changes in Access to Any Drug Coverage for Beneficiaries with Access to at Least One M+C Plan
1999-2000
Negative change indicates drop in coverage.

State	1999	2000	Change
OK	100%	100%	0%
OR	65%	66%	1%
PA	97%	93%	-4%
RI	100%	100%	0%
SC	0%	0%	0%
SD	0%	0%	0%
TN	81%	82%	1%
TX	96%	95%	0%
UT	0%	0%	0%
VA	63%	100%	37%
VT	0%	0%	0%
WA	10%	88%	78%
WI	100%	100%	0%
WV	62%	0%	-62%
WY	0%	0%	0%

ATTACHMENT B

Beneficiaries with Access to an M+C Plan 1999 to 2000 *Negative change indicates drop in coverage.*			
State	**1999**	**2000**	**Change**
AK	0.0%	0.0%	0.0%
AL	28.6%	28.6%	0.0%
AR	31.0%	31.1%	0.1%
AZ	100.0%	94.3%	-5.7%
CA	95.1%	95.0%	-0.1%
CO	81.2%	81.7%	0.4%
CT	100.0%	97.1%	-2.9%
DC	100.0%	100.0%	0.0%
DE	58.0%	100.0%	42.0%
FL	84.1%	82.6%	-1.5%
GA	36.6%	34.8%	-1.8%
HI	95.0%	100%	5.0%
IA	2.9%	2.9%	0.0%
ID	28.4%	28.6%	0.2%
IL	68.5%	68.5%	0.0%
IN	34.6%	34.7%	0.1%
KS	35.2%	35.3%	0.1%
KY	25.8%	25.8%	0.0%
LA	87.1%	59.6%	-27.5%
MA	96.9%	97.1%	0.2%
MD	100.0%	82.0%	-18.0%
ME	62.8%	63.1%	0.3%
MI	62.6%	62.7%	0.1%
MN	48.4%	48.6%	0.2%
MO	58.5%	58.6%	0.2%
MS	0.0%	0.0%	0.0%
MT	0.0%	0.0%	0.0%
NC	46.8%	47.0%	0.2%
ND	0.0%	0.0%	0.0%
NE	26.0%	23.4%	-2.7%
NH	64.5%	46.7%	-17.8%
NJ	100.0%	100.0%	0.0%
NM	65.5%	65.9%	0.4%
NV	88.7%	89.6%	0.9%
NY	91.0%	90.6%	-0.4%
OH	84.9%	87.0%	2.1%
OK	80.7%	77.4%	-3.3%

Beneficiaries with Access to an M+C Plan 1999 to 2000 *Negative change indicates drop in coverage.*			
State	1999	2000	Change
OR	81.6%	81.1%	-0.4%
PA	96.2%	96.3%	0.1%
RI	100.0%	100.0%	0.0%
SC	11.6%	0.0%	-11.6%
SD	0.0%	0.0%	0.0%
TN	73.5%	60.1%	-13.3%
TX	73.3%	71.5%	-1.8%
UT	0.0%	0.0%	0.0%
VA	53.1%	33.5%	-19.6%
VT	0.0%	0.0%	0.0%
WA	84.7%	82.6%	-2.1%
WI	42.8%	50.6%	7.8%
WV	36.2%	20.5%	-15.7%
WY	0.0%	0.0%	0.0%

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